New Hampshire

UNIFORM APPLICATION
FY 2009 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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New Hampshire

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_ FY2009 ___ FY 2009-2010 ___ FY 2009-2011

STATE NAME: New Hampshire

DUNS #: 178-519-609

I. AGENCY TO RECEIVE GRANT

AGENCY: Bureau of Behavioral Health

ORGANIZATIONAL UNIT: Division of Community Based Care Services

STREET ADDRESS: 105 Pleasant Street

CITY: Concord STATE: NH ZIP: 3301

TELEPHONE: 603-271-5048 FAX: 603-271-5040

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Erik Riera TITLE: Bureau Administrator

AGENCY: Bureau of Behavioral Health

ORGANIZATIONAL UNIT: Division of Community Based Care Services

STREET ADDRESS: 105 Pleasant Street

CITY: Concord STATE: NH ZIP CODE: 3301

TELEPHONE: (603) 271-5007 FAX: 603-271-5058

III. STATE FISCAL YEAR

FROM: 07/01/2008 TO: 06/30/2009

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: Lee Ustinich TITLE: Program Planning and Review Specialist

AGENCY: Bureau of Behavioral Health

ORGANIZATIONAL UNIT: Division of Community Based Care Services

STREET ADDRESS: 105 Pleasant Street

CITY: Concord STATE: NH ZIP: 3301

TELEPHONE: 603-271-5048 FAX: 603-271-5040 EMAIL: lustinich@dhhs.state.nh.us

New Hampshire

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

Executive Summary

New Hampshire is home to approximately 1,309,940 people. In state fiscal year (SFY) 2007 approximately 46,909 individuals (or 3.5% of the population) were engaged in the public mental health system. Of those, 8,718 were State-eligible adults with serious mental illness and 8,028 were State-eligible children with serious mental emotional disturbance, for a total of 16,746, or 36% of those served in the public system. Services to the eligible population are provided through contracts with ten Community Mental Health Centers, in ten regions covering the state.

The Bureau of Behavioral Health (BBH) is the State Mental Health Authority, responsible for planning, coordinating services, contracting, regulating, and monitoring the State's system of public mental health services for individuals across the lifespan. New Hampshire Statutes and Administrative Rules detail the Bureau's authority. Through interagency agreement BBH maintains specific management and administrative authority over community mental health services. The Bureau has sole policy making authority as it pertains to BHH services. BBH administers the mental health block grant for community services, maintains the State Mental Health Planning and Advisory Council, and develops the State Plan as required by that grant.

The Bureau's leadership role within the larger public systems provides a strong voice for the transformation of the mental health system. Values being clearly articulated include viewing services for persons with mental illness, including those with co-occurring disorders, as an equally important component of primary heath care, across the age span. Bureau leadership is highly involved in formulating plans to reduce psychiatric hospitalizations by increasing community-based supports and tackling other critical issues that impede access to timely and effective services for citizens utilizing the public mental health system. Some of the highlights, challenges, and changes in this year's State Plan are summarized below.

➢ New Hampshire is "the Granite State" and the State motto is "Live Free or Die". These few words capture the rock-solid, tenacious, independent, and spirited character of the majority of those involved with the mental health system, a system primarily of strengths. Among the core strengths of this system are these: Continuous quality improvement activities; continual updating and upgrading of data information systems; commitment to establishing, maintaining, and expanding Evidence-Based Practices (EBPs); fiscal soundness and accountability; attention to necessary revisions to the Administrative Rules governing the mental health system; inclusion of consumers, family members, and interested others in the planning process, and; a determination among all stakeholders to regain ground lost over the years, by identifying and implementing the best research-to-practice modalities available within the fiscal realities.

➢ For the first time the State Plan has been made available to the citizens of New Hampshire for review and comment via the Internet. Notices and instructions were sent to a large number of stakeholders. Electronic copies were also e-mailed and print copies were made available to the Planning Council for their review. Print copies of the State Plan are also made available to other stakeholders throughout the year.

➢ The State Planning Council's collaboration with the Bureau of Behavioral Health addresses the transition practices in the public mental health system for youth and young adults (age 14

through 24). State Transformation performance measures were created as a result of this collaboration, in SFY08. The initiative on the transition of youth and young adults is resulting in increased communication, collaboration, and funding among multiple agencies.

➢ Primary areas needing attention have not changed over recent years, and have become fairly critical: they include the need for housing, more community supports to prevent hospitalization, mental health workforce retention and development, capacity for community based inpatient psychiatric care, services for special populations, and establishing integrated children's services.

➢ New developments include data initiatives to provide unduplicated counts and improved consumer satisfaction survey data. A technical assistance grant has enabled training in Person Centered Treatment. The previously inactive Office of Consumer Affairs has been reactivated as the Office of Consumer and Family Affairs. Recommendations from the Mental Health Commission were released and a taskforce to reduce utilization of New Hampshire Hospital (the State's only psychiatric hospital) has been established which will provide essential information for future planning, via a formal Ten Year Plan addressing most of the critical needs. The EBPs Assertive Community Treatment (ACT) and Disruptive Behaviors are being introduced in the adult and children's systems, respectively.

➢ Legislation has addressed issues such as conditional discharges, emergency interventions, and procedures regarding involuntary admission, emergency treatment, and lack of capacity to make informed treatment decisions. Additionally, the Administrative Rule governing the service array is being revised to conform to the federal regulations for Targeted Case Management.

➢ The regional planning process is being evaluated for an upcoming revision to the Rule governing that process. All of the Peer Support Agencies are involved in training in Intentional Peer Support, with a view to certification in the future and the implementation of SAMHSA's pending release of the evidence-based practice Toolkit for consumer-run peer support organizations. Reviews of all Peer Support Agencies are being conducted under the Quality Improvement initiative. Fidelity reviews of EBPs and CMHC reapproval reviews continue. Dartmouth Psychiatric Research Center is now under contract to conduct the fidelity reviews

➢ New State performance measures are under development or under consideration, to expand the effective utilization of our state-level data in a manner that will help to inform and to drive policy and budget planning over the long term.

➢ A new focus is on providing information to consumers of public mental health services, through regional workshops. A workshop put on by the Office of Community and Family Affairs and the Dartmouth Psychiatric Research Center was held to identify areas that consumers seek further information about. Included are Person-Centered Treatment Planning, Illness Management and Recovery, Supported Employment, and Effective Communication, from the consumer's perspective. As a result the Bureau's contract for Dartmouth has been modified to incorporate these workshops and trainings for consumers.

See Appendix A: 1 for a List of Acronyms used throughout this application.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2009

I hereby certify that New Hampshire agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a service area)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Signature Date

Erik Riera, Administrator, Bureau of Behavioral Health

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION NH Bureau of Behavioral Health	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. Federal Department/Agency:	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____
Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in con- struction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION NH Bureau of Behavioral Health	DATE SUBMITTED

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New Hampshire

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

Public Comments on the State Plan

New Hampshire posted its State Plan and Implementation Report on the State website for the first time in 2007 and will continue to do so. This method now provides the public with a year-round opportunity to view and comment on the most recent Plan and Report, with the postings updated annually. Comments can be made by e-mail, telephone, or in writing to the state planner. Persons or agencies without Internet access may request one print copy of the Plan. Different approaches for driving traffic to the site and to reach those with limited access to State-published material will be tried during FY09.

http://www.dhhs.state.nh.us/DHHS/BBH/LIBRARY/Program+Report-Plan/block-grant.htm

The FY09 State Plan drafts in progress will be uploaded to the WebBGAS website to allow for immediate State Planning Council access and comments. Access for public comments from the citizenry will be made available throughout the first three weeks of August 2008, when the text for review is final or close to final. Flyers will be provided to the Community Mental Health Centers, their board members, the Peer Support Agencies, and other stakeholder organizations for posting at their sites, directing the public to the WebBGAS site. This is the first time that public access to the WebBGAS application has been tried.

Table 3	Who Does the New Hampshire Public Mental Health System Serve?		
Setting	**Eligibility**	**Services**	**Funding**
Community Mental Health Centers	Meets State eligibility for Serious Mental Illness (SMI-adults) or Serious Emotional Disturbance (SED-children) and is Medicaid eligible	All services available to SMI or SED population **Rule permits youth to age 21 to remain in the Children's MH system with a note from the MD	Medicaid; State funds; insurance; self-pay; grants, e.g. United Way
Community Mental Health Centers	Meets State eligibility for SMI or SED but is not Medicaid eligible	All services available to SMI or SED population **See note on Rule above; same applies	CMHC; Medicare; insurance; self-pay; grants
Community Mental Health Centers	Does not meet State eligibility for SMI or SED	Full array of Outpatient Services	Insurance; self-pay; grants; may be limited charity support in some communities
Peer Support Agencies	Self-report of mental illness	All services of the Peer Support Agency	Mental Health Block Grant; State funds
Family Mutual Support (community-based)	Families of youth with SED to age 18	Individual and group family-to-family support and education	State funds
Emergency Services	Psychiatric Distress	Assessment; consultation; intervention; crisis counseling (6 sessions per episode of acute illness)	CMHC; insurance; Medicaid, Medicare
New Hampshire Hospital (includes the Anna Philbrook Center for children)	Hospital level of care	Service array for acute inpatient care	State funds; some Medicare/insurance; some Medicaid under age 22 or over age 65

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2007	Estimate/Actual FY 2008
$3,828,725	$13,200,497	$13,687,278

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2006	Actual FY 2007	Actual/Estimate FY 2008
$42,567,285	**$43,936,377**	**$44,381,467**

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Bailey, Daniel	Consumers/Survivors/Ex-patients(C/S/X)		PO Box 306 Main St. Contoocook,NH 3229 PH:603-746-4470 FAX:	nhwave@tds.net
Barrett, Ray	Providers	CMHC	771 North Main St Laconia,NH 3246 PH:603-524-1100 ext 170 FAX:	rbarrett@genisisbh.org
Bilson, Michael	State Employees	Mental Health	105 Pleasant St Concord,NH 3301 PH:603-271-5045 FAX:	mbilson@dhhs.state.nh.us
Collica, Nancy	Family Members of Children with SED		12 Old Auburn Rd Derry,NH 03038 PH:603-930-4356 FAX:	ncollica@aol.com
Collins, Elizabeth	State Employees	Other	129 Pleasant St Concord,NH 3301 PH:603-271-8181 FAX:	ecollins@dhhs.state.nh.us
Daigle, Denise	Others(not state employees or providers)	Mental Health and Aging Consumer Advisory Council	93 Lynwood Ln Manchester,NH 3109 PH:603-666-3658 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Dawson, John	State Employees	Other	45 South Fruit St Concord,NH 3301 PH:603-271-5976 FAX:	jdawson@dhhs.state.nh.us
Drysdale, Kimberly	Providers	LRCAB-Cornerbridge Concord Peer Support	55 School St Concord,NH 03301 PH:603-224-0083 FAX:	pagand2004@yahoo.com
Ferber, Claudia	Providers		15 Green St Concord,NH 3301 PH:603-225-5359 FAX:	cferber@naminh.org
Gerhardt, Christine	State Employees	Social Services	129 Pleasant St Concord,NH 3301 PH:603-271-4697 FAX:	cgerhardt@dhhs.state.nh.us
Gray, Don	Others(not state employees or providers)	Small Business Community	430 Union Ave Laconia,NH 03246 PH:603-581-9788 FAX:	sirdon@metrocast.net
Gray, Molly	Family Members of adults with SMI		PO Box 521 West Swanzey,NH 03469 PH:603-352-5813 FAX:	gray_molly@hotmail.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Harrison, Lamont	Consumers/Survivors/Ex-patients(C/S/X)		PO Box 615 Londonderry,NH 3053 PH:603-434-5255 FAX:	harrison132@yahoo.com
Harrison, Suzanne	Family Members of Children with SED		PO Box 615 Londonderry,NH 3053 PH:603-434-5255 FAX:	sharrison@harrisonconsult.com
Hawkins, Lisa	Consumers/Survivors/Ex-patients(C/S/X)		84 Silver St Dover,NH 03820 PH:603-343-4998 FAX:	
Hill, Dennis	Providers	AIDS Service Organization	8 Wall St Concord,NH 03301 PH:603-226-0607 FAX:	dhill@mvap.org
Hunter, Donald	State Employees	Medicaid	129 Pleasant St Annex 1 Concord,NH 3301 PH:603-271-5255 FAX:	donald.r.hunter@dhhs.state.nh.us
Jensen, Egon	State Employees	Other	129 Pleasant St Concord,NH 3301 PH:603-271-7320 FAX:	ejensen@dhhs.state.nh.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lane, Mary	State Employees	Education	101 Pleasant St Concord,NH 3301 PH:603-271-3740 FAX:	mlane@ed.state.nh.us
McCartin, Mac	Family Members of adults with SMI		9 Rossini Rd Londonderry,NH 03053 PH:603-432-1477 FAX:	mccartin@comcast.net
McDermott, John	State Employees	Criminal Justice	1056 North River Rd Manchester,NH 3104 PH:603-669-1203 ext 360 FAX:	jmcdermott@dhhs.state.nh.us
McDougall, Shirley	Consumers/Survivors/Ex-patients(C/S/X)		388 NH RTE 175 Campton,NH 3323 PH:603-536-4074 FAX:	shirleymcd@gaufo.com
Moore, Donald	Family Members of adults with SMI		PO Box 143 New Castle,NH 3854 PH:603-436-3264 FAX:	donmoore@eml.cc
Orsini, Karen	State Employees	Mental Health	105 Pleasant St Concord,NH 3301 PH:603-271-5053 FAX:	korsini@dhhs.state.nh.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Payson, Patricia	Family Members of adults with SMI		15 Appaloosa Ave Pelham,NH 3076 PH:603-635-2734 FAX:	patriciapayson@aol.com
Press, Steven	Providers	CMHC	15 Prospect St Nashua,NH 3060 PH:603-889-6147 FAX:603-594-9649	press@ccofnashua.org
Sawyer, David	Consumers/Survivors/Ex-patients(C/S/X)		6 Spinney Ln Durham,NH 3824 PH:603-868-2568 FAX:	davidsawyer@thelifeline.net
Schow, Harvey	Others(not state employees or providers)	CMHC Board Member	88 Birchwood Rd Manchester,NH 3104 PH:603-622-0945 FAX:	suwharv@comcast.net
Shaw, Lisa	State Employees	Vocational Rehabilitation	21 Fruit St. Suite 20 Concord,NH 03301 PH:603-594-9649 FAX:603-271-7095	lshaw@ed.state.nh.us
Smith, Peter Evan	Consumers/Survivors/Ex-patients(C/S/X)		99 Hawkins Rd Winchester,NH 03470 PH:603-352-5093 FAX:	peterevansmith@yahoo.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Sparks, Robert	Family Members of adults with SMI		486 Nashua St. Unit 109 Milford,NH 03055 PH:603-271-7096 FAX:	rsparks@dhhs.state.nh.us
Szostak, Gail	Family Members of Children with SED		46 Warren St Apt 312 Concord,NH 3301 PH:603-228-4298 FAX:	gailszostak@verizon.net
Ustinich, Lee	State Employees	Mental Health	105 Pleasant St Concord,NH 3301 PH:603-271-5048 FAX:	lustinich@dhhs.state.nh.us

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	33	[redacted]
Consumers/Survivors/Ex-patients(C/S/X)	6	[redacted]
Family Members of Children with SED	3	[redacted]
Family Members of adults with SMI	5	[redacted]
Vacancies(C/S/X and Family Members)	0	[redacted]
Others(not state employees or providers)	3	[redacted]
TOTAL C/S/X, Family Members and Others	17	51.52%
State Employees	11	[redacted]
Providers	5	[redacted]
Vacancies	1	[redacted]
TOTAL State Employees and Providers	16	48.48%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

New Hampshire

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

Planning Council Charge, Role and Activities

"The Council is charged with focusing its statutory duties in a manner that will influence the public mental health system. The goal is to increase the capacity of consumers, family members, State agency representatives, stakeholder groups, and the public, to provide well-informed comments and recommendations to the State regarding the State Plan for community-based mental health services."

The charge, formally issued at the June 10, 2008 Council session, evolved from opening remarks on "Focusing the State Council", delivered at the official convening of the NH Mental Health Planning and Advisory Council in January 2007. It was noted that one meaning of focus is "a thing that is of greatest importance to an activity or interest". The Council's greatest focus is on improving the mental health system in New Hampshire.

To appreciate the Council's current role in the State's efforts to transform the mental health system, understanding the history is important. This Planning Council unifies members of two former councils, one for adults and one for children, which were dissolved in 2006. The Bureau of Behavioral Health (BBH) established and recognized the single Council with the goal of strengthening New Hampshire's Planning Council by enabling all those appointed to the Council to be at the same table at the same time.

"The Mission of the Council is to bring consumers and families representing children and adults, across the life span, and other stakeholders, together as partners and advocates in the creation, expansion, planning, monitoring, and evaluating of the mental health services and systems of care throughout New Hampshire." The Mission Statement was adopted in March 2007. The Planning Council's focus on integrating mental health planning among multiple systems, across the age span, should significantly influence and impact the public system.

The interval between the summer of 2006 and the spring of 2007 was a time of transition that included the expiration of the separate councils, the establishment of the single Council, the election of officers, and the selection of work group chairs. Temporary bylaws were used and then revised, and adopted as permanent in January 2008. The bylaws are included in Appendix A (2) and specify the policies and procedures for the selection of Council members, their terms, the conduct of meetings, the duties of the Council and other core aspects of Council operations.

Members serve for a term of four years. Potential applicants are selected based on the priority needs of the Council, prior to making a recommendation to the State Mental Health Authority (SMHA) for appointment. The Bureau's Executive Director issues the appointment to serve on the Council. Council sessions are currently convened monthly and presided over by the Council co-chairs. Meetings follow an order of business and a written agenda. A description of essential rules of order, per the bylaws, has not yet been drafted, but a simplified, derivative version of Robert's Rules is available for guidance as needed.

The Council currently has 33 members, plus 1 vacancy. The bylaws require a composition of 51% consumers, family members and other (C/F/O), and 49% State employees and providers (SE/P). The 1 vacancy is the required criminal justice appointment from adult corrections. The

current Council composition is 52% C/F/O and 48% SE/P. The Council structure provides for four officers: two co-chairs, one representing adult consumers over age 18 with SMI and one a family member of a child with SED, and two vice co-chairs, representing adults and children as described above. The Council is governed through an Executive Committee (the "EC").

The EC includes the four officers, chairs of four work groups, and the state planner. The children's planner may also sit on the EC. The state planner(s) serve on the EC in a consultation role and do not vote. The EC is the Council's formal liaison to the Bureau, so the ability for direct and ongoing dialogue between the Council representatives and the SMHA, taking place face-to-face within the EC meetings, has proven to be an effective and timely communication mechanism and one in which different perspectives can be readily addressed.

The EC is to: (1) provide oversight and guidance to the Council membership regarding the statutory duties of the Council; (2) implement the results of Council voting, and; (3) solicit and consider input from all members prior to proposing any significant changes affecting the Council's operations, structure, priorities, or bylaws.

The Bureau offers technical assistance to the Council's work groups regarding the community mental health system. Staff who provide technical assistance include, but are not limited to, the Quality Improvement coordinator, the Data Management specialist and the director of the Office of Consumer and Family Affairs. The Council has joined the National Association of Mental Health Planning and Advisory Councils (NAMHPAC) and has invited the Association to come and provide training in Council leadership and development. Although there is a set of bylaws, there is a need for more detailed planning regarding the "how to's" and "who should's" of Council procedures, and this endeavor is in process.

The Council work groups are still in the early stage of integrating the Council's priorities in an interactive, collaborative and coordinated fashion. The "grandfathered" majority of the membership base must make a significant paradigm shift from the old models to the new Council's heightened focus on specific activities. Members new to the Planning Council are readily responsive to the work involved but are also in the early stage of attaining familiarity with the State Plan, the public mental health system, and the duties and influential role of the planning councils nationwide.

The Council is beginning to distinguish itself as an advisory body and the current SMHA administrators are attentive to input from the Council. Strategic recruitment is slowly but steadily resulting in appointments of persons who are engaged in the hands-on work of the Council. The informal orientation of potential members ensures that the level of individual commitment is fully disclosed and understood, prior to someone applying for a seat on the Council.

Report of the Planning Council's Efforts and Related Duties as Mandated by Law

Key activities since the 2007 Council formation are identified below.

(1) Establishing four work groups to address monitoring and evaluation of the state MH system, state planning, advocacy opportunities, and membership development

(2) The adoption of bylaws
(3) The election of officers
(4) Establishing a planning calendar to map out major events and tasks, such as contracted trainings, formal review of the State Plan, NAMHPAC technical assistance, and the all-Council annual planning meeting
(5) Beginning work on a Council Handbook that will manualize procedures for essential Council operations, supplementary to the bylaws
(6) Collaborating with the SMHA on State Transformation measures addressing youth/young adult transition practices in the public mental health system

This latter initiative absorbed much of the Council's activity during SFY08. It is a highly significant accomplishment because not only has the Council provided a meaningful work product, but also it is the first time ever that the interaction between the Council and the Bureau of Behavioral Health has resulted in an actual addition to the State Plan. The Council identified "transition" as one of its top three priorities across the age span, from among the unmet needs of the public system noted in the FY07 State Plan.

The initiative on the transition of youth and young adults is resulting in increased multi-agency cross-communication. The heightened call for the integration of services, including the mental health care and medical primary care interface, is exemplified in part by the work on transition practices and is reflected to some degree in all the activities of the State Planning Council. This has raised awareness within both DHHS and other Departments about the special needs of this population, and the difficulties posed for youth/young adults moving among multiple systems.

The Council's work on transition in FY08 influenced a funding decision to allocate a small percentage of the block grant, over a three-year period, to seed the start-up of a new initiative under Project RENEW, a national model for services to transitional aged youth. This is the first time that the block grant funds have not been allocated solely to the Peer Support Agencies and Council support. The PSA contracts were not adversely affected as a result of the re-distribution. The Council had expressed concerns about allocating all of the funds to a single purpose, which has been the practice for many years, and this disbursement appears to be fair for all concerned.

Additionally, the priority on transitional aged youth has resulted in BBH submitting an application for a policy academy on transitional aged youth at Georgetown University in the winter. This application is being submitted through the Governor's Office.

A Council Handbook will include details for carrying out and maintaining the core operations and activities of the Council and is in partial draft form. The state planner requested that protocols and procedures be developed in collaboration with the Bureau, to help ensure a true partnership with the State, designed to increase the Council's participation in the planning efforts to transform the mental health system. The EC is in the process of forming an ad hoc committee to oversee the project. It is anticipated that once operational, the Handbook will provide consistency in Council procedures throughout cycles of term limits and leadership changes.

Some of the Council's efforts and activities to date are described below:

ADVOCACY

(1) The Council sent a letter to the DHHS Commissioner advocating that a waiver be granted to permit the hiring of a Children's Services State Planner, during the current hiring freeze.
(2) The Advocacy Work Group is researching and developing a public information brochure discussing mental illness myths vs. realities, which is targeted to legislators.
(3) The Executive Committee offered suggestions to the Advocacy Work Group chair for increasing the group's familiarity with legislative issues. Materials listing relevant legislation were provided to the group and the Bureau's legal counsel offered hands-on instruction in how to track bills online. The Disability Rights Center and NAMI-NH provide timely information for advocacy purposes, along with other resources disseminated by the Office of Community and Family Affairs. Council members have full access to these resources.
(4) The ongoing commitment to support the State transformation measures on youth and young adult transitions between the child and adult MH systems is inherently a major advocacy activity.

MONITORING AND EVALUATION

(1) A formal monitoring, review and evaluation of the adequacy and allocation of the State's services is deferred until SFY09, while the Monitoring and Evaluation Work Group determines how it will approach this task. The Bureau has provided extensive technical assistance to assure that the group has awareness of the Quality Improvement reports available to the Council, as well as the types of data that can be generated. The delay in identifying activities under this mandate is due in part to the dissolution of the former separate councils, which did not have a defined process for this task. The Council is supported by BBH in taking the time needed for the Council to familiarize itself with how this mandate is approached by other Councils across the country and to assess and adapt that knowledge to be of service for New Hampshire. A written protocol to guide the process is anticipated prior to the end of the calendar year.
(2) The Work Group re-reviewed the FY07 Implementation Report as a preparation exercise for the FY08 report and provided input for the FY09 plan.
(3) An inventory was taken of the consumer/family representation on Community Mental Heath Center Boards and a letter was sent to the Bureau recommending that the language of Administrative Rule He-M 403.03(b)(4) b., regarding consumer/family representation on CMHC boards, should specify a certain percent of consumer/family seats on boards.
(4) Some members have expressed interest in providing input to the revision of Administrative Rule He-M 403.08 and .09, regarding the regional planning process, when the review of the Rule begins in 2009.
(5) The work group arranged for a presentation to the Council by the contracts manager for the Peer Support Agencies, which receive the majority of block grant funds. The presentation provided basic information regarding the fiscal oversight and accountability of these agencies and plans to implement Intentional Peer Support. The presentation was prompted by the Council's interest in quality assurance aspects related to the utilization of the block grant funds.
(6) The provision of training on utilization of NH's data from the Population Overlap Estimation project and the MHSIP survey is a NH DIG contractual element supported by the Council. The trainings will be held in calendar 2008 and are anticipated to be a crucial element for future monitoring and evaluation of the community-based system.

STATE PLAN REVIEW

(1) The State Plan Work Group developed a structured approach for the review of the State Plan, and completed a written protocol for the Council's review of the State Plan and Implementation Report, which the Council adopted. See Appendix A (3). This is a first in the history of the review of the block grant in New Hampshire, and is expected to serve the Council well.
(2) The State Plan group, in collaboration with the Bureau, developed two new State transformation measures, on the transition practices for youth age 14-17 and young adults 18-24 in the mental health system.
(3) The State Plan Work group, in collaboration with the full Council, developed and published a position paper with recommendations on transition practices for youth and young adults with SED moving from the children's to the adult system.
(4) The Council is continuing to address the transition issues of adolescents and young adults and is developing the FY09 action plan for the measures.
(5) Through the Executive Committee, the work group chairs are guiding the membership in linking Council work products to the State Plan, per the NOMs.
(6) The Council is beginning to utilize the expertise of State employees and providers to the fullest. In addition to having periodic speakers present on their agency's mental health-related activities, the interagency communication regarding issues of mental health State planning and the Council priorities have increased and improved. It should be noted that one of the Bureau's expectations is that the cross-agency dialogue, to include the voices of consumers, family members, and others, would be strengthened sufficiently to have an impact on the system, including across the applicable Departments. This is another example of the importance of the Council-SMHA partnership in addressing public services across the age span.

COUNCIL DEVELOPMENT

(1) The Membership Work Group brought the combined membership records current and established a record keeping procedure that includes a Master Roster and an Attendance Tracker. The Attendance Tracker provides the monthly data to track composition ratios, level of participation, quorum counts, annual statistics, and data for use in periodic reports on membership trends and status.
(2) The Tracker enables the Council to take outreach action early on when a member is becoming inactive. A tiered process for re-engagement was designed to increase the participation of absentee appointees, or to free up the seat so that the Council may maintain the necessary level of member support. If repeated contact by a representative of the work group is unsuccessful, the Council officers are tasked with handling the issue. Standards for the officers and work group chairs are going to be developed shortly. The Bureau commends the Council for taking on the sensitive and difficult task of constructively confronting excessive absenteeism and sustained lack of active participation in the work of the Council and the individual subgroups.
(3) A Membership Development Plan was created and submitted to CMHS in response to a modification requirement for the Council from the FY08 Peer Review.
(4) A Membership Work Plan with timeline to conduct the development plan was also created, although a low level of participation in this small group has significantly hampered progress. The work group chair is enlisting the help of all Council members, on an urgent basis, to implement the required modifications prior to the FY09 Peer Review and FY08 Implementation Report. The

Council continues to problem-solve ways to include viable representation from distant areas, parents of young children, older adults, and minority groups.
(5) A project was attempted to engage one of more representatives from the MH & Aging Council in teleconferencing with the Advocacy group. While that effort was unsuccessful, the strategy will be attempted with other potential participants. The Bureau supports the Council in seeking alternatives to in-person attendance for situations in which that is impossible and the candidate is motivated to participate effectively.
(6) A Contact List has been made that identifies the membership type and which work group each member is primarily affiliated with, along with the contact information. A mailing list for non-members wishing to receive the Council minutes has also been established. Templates have been created for membership-related letters and the application was updated in FY08.
(7) The work group created a Welcome Packet for new guests and a New Member Orientation will be developed by the end the calendar year, following training from NAMHPAC.
(8) Council development activities, beyond the basics of membership maintenance, have not yet been defined sufficiently to ascribe specific tasks to appropriate subgroups or ad hoc committees, but the Executive Committee is turning its attention to these matters as they emerge. The Council officers, as ex-officio members of all work groups, are expected to provide much of the coordination and facilitation to help the Council meet its charge and fulfill its mission.

New Hampshire

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of the State's Mental Health System: Adult System

New Hampshire statute Chapter 135-C, Section 135-C: 3 establishes the State mental health services system. New Hampshire's mental health service system is organized under the Department of Health and Human Services (DHHS). The State Mental Health Authority (SMHA), the Bureau of Behavioral Health (BBH), is mandated to ensure the provision of efficient and effective services to those citizens who are most severely and persistently disabled by mental, emotional, and behavioral impairments.

The Bureau of Behavioral Health is located within the Division of Community Based Care Services (DCBCS). The DCBCS provides a wide array of community supports and services in partnership with community systems. The Division is made up of four functional areas: the Bureau of Behavioral Health, the Bureau of Developmental Disabilities, the Bureau of Homeless and Housing Services, and the Bureau of Elderly and Adult Services.

New Hampshire's Bureau of Behavioral Health is responsible for planning, coordinating services, contracting, regulating, and monitoring the State's system of public mental health services for individuals across the lifespan. New Hampshire Statutes and Administrative Rules detail the Bureau's authority in relation to other State agencies. Through interagency agreement BBH maintains specific management and administrative authority over community mental health services. The Bureau has sole policy making authority as it pertains to BBH services.

The Bureau manages the budget and appropriations for specific services under Title XIX of the Social Security Act, which is administered by the Centers for Medicaid and Medicare (CMS). BBH maintains responsibility for the determination and redetermination of individuals for community mental health services as outlined in administrative rule. Community Mental Health Services in NH are covered under the Medicaid State Plan Rehab Option and Targeted Case Management Options. The BBH Office of Administrative Services is responsible for all applicable information per Federal Medicaid regulations and other information and correspondence related to the operations of the BBH Medicaid Program.

At the local level the majority of community-based mental health services are delivered by Community Mental Health Centers (CMHCs), local mental health authorities that contract with the Bureau of Behavioral Health. The state is apportioned into ten mental health service areas (Regions I through X); statewide coverage is provided by the location of one CMHC in each of the ten regions. New Hampshire is home to approximately 1,309,940 people. In FY07 approximately 46, 909 individuals were engaged in the public mental health system. FY08 data is not yet available.

Regional planning for all ages is required by Administrative Rule He-M 403. Regional planning for services for children and adolescents with serious emotional disturbance (SED) additionally mandates shared service responsibility with other State agencies serving children and youth and their families. This includes, but is not limited to, the Department of Education (DOE). Psychiatric Emergency & Crisis Services in New Hampshire are available 24 hours a day, 7 days a week to any person who may be experiencing psychiatric distress.

Peer Support Agencies (PSAs) are community-based private not-for-profit agencies that have contracted with BBH to provide peer-to-peer support by people with mental illness, intended to assist people with mental illness in their personal recovery. In NH, the mental health block grant (MHBG) funds are used to partially support nine PSAs and their satellite sites. Peer support is provided statewide.

New Hampshire Hospital (NHH) is a fully accredited public state-operated psychiatric facility with 230 licensed beds serving children, adults and elderly populations. It is the only freestanding facility in the State serving this population. It is managed in clinical partnership with Dartmouth Medical School. NHH provides psychiatric and neurological care in two program areas: hospital-based services for older teens and adults, and; services for NHH clients residing in transitional housing that is located on the grounds. The objective of both programs is the placement of all patients and residents into the community. The Anna Philbrook Center, located on the hospital campus, provides children's inpatient services.

Mental health treatment services available within the correctional system are dependant upon the inmate's location in the system. At the state level the Department of Corrections (DOC) operates a full array of mental health services in what DOC terms the "outpatient" unit inside the state prison. For inmates requiring inpatient care, referral is made to the Secure Psychiatric Unit (SPU), located within the State Prison for Men in Concord, NH. The SPU is a 40 bed unit established by state statute to house and treat a mixed population of severely mentally ill persons. The residents include mentally ill prison inmates, mentally ill jail inmates, criminal and civil commitments.

At the county level each of the ten county jail facilities are independently operated and vary in the level of mental health services provided. The New Hampshire Department of Health and Human Services contracts for sex offender treatment at Transitional Housing Services for the Mentally Ill and NHH Acute Psychiatric Services. Inmates that require sub-acute residential treatment can now reside in the Residential Treatment Unit (RTU), a 20 bed unit housed next to the SPU

Glencliff Home is a 106-bed nursing home that provides long term care for mentally ill or developmentally disabled elderly adults. Glencliff provides a continuum of services in a home-like atmosphere with an emphasis on independence, rehabilitation and, whenever possible, a return to the community.

Organizational charts of the Department of Health and Human Services, the Division of Community Based Care Services, and the Bureau of Behavioral Health are included in the Appendix (4). The Governor, the Honorable John Lynch, appointed a new commissioner of the DHHS in 2007, Nicholas Toumpas. Commissioner Toumpas is actively working to transform the mental health system, including increasing cross-agency interactions and planning efforts.

New Hampshire

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Summary of Areas Previously Identified by State as Needing Attention: Adult System

The areas previously identified as needing attention and significant achievements impacting some of the areas needing attention also support the President's New Freedom Commission's goals for transformation activities.

1. Housing, both transitional and permanent: Transitional Housing Services constructed a ninth house, with six units, on the campus of New Hampshire Hospital, near the downtown area of Concord. The house expands the hospital's capacity to discharge patients to a transitional living environment.

2. Community supports to prevent hospitalization: The Individualized Resiliency and Recovery Oriented System (IROS) provides for Functional Support Services (FSS) that include Crisis Services, Medication Management, Family Support, and Therapeutic Behavioral Services. IROS is more congruent with enhancing flexible supports in the consumer's natural environment than the former system.

3. Workforce development, including professional staff shortages: The Bureau's relationships with New Hampshire's public and private colleges and universities are of paramount importance in the development of a strong mental health system. BBH has developed relationships with Dartmouth Medical School, the University of New Hampshire, and the New Hampshire Post Secondary Technical Education System for a variety of activities designed to promote the development of skilled human resources, engage in services and clinical research, and market mental health careers to potential staff.

4. Insufficient psychiatric crisis beds in community hospitals: No significant achievements; recently, the plan to establish beds in central New Hampshire did not result in a contract.

5. Services for special populations: Integrated Illness Management and Recovery (I-IMR) was implemented in Nashua (Region VI) and Manchester (Region VII). I-IMR is an adaptation of the evidence based practice IMR that integrates self-management skills for both psychiatric and medical illness by embedding primary health care management for common medical disorders into the mental health service setting, for adults age 50 and over with SMI. The Mental Health Center of Greater Manchester (Region VII) was presented with an award of excellence by SAMHSA for the provision of Integrated Dual Disorders Treatment (IDDT).

6. Development of the Peer Support Agencies: An MOU was developed in fiscal year 2008 to include new fiscal accountability measures. In fiscal year 2009 the MOU has been expanded to include indicators related to consumer control and Board of Directors development. Staff began training to become certified in Intentional Peer Support. Data collection is being enhanced through the implementation of a new data gathering and reporting process.

New Hampshire

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues: Adult System

Statistical analysis provided by the Bristol Observatory of Vermont is enhancing New Hampshire's understanding of the array of services that people served in the CMHCs receive from multiple other sources. The Population Overlap Estimation (POE) project produces the unduplicated number of persons in the system and the numbers served by both the mental health system and each of the following: Corrections, Housing and Homeless, Labor, Justice, Education, Substance Abuse, private hospitals, and residential treatment centers for children.

The Institute on Disability (IOD) at the University of New Hampshire, per contract with BBH, has conducted the FY08 state-wide MHSIP (Mental Health Statistical Improvement Program) consumer survey of people in the public mental health system. The data is reported in the URS (Uniform Reporting System) tables, which contain the federally-required data for the block grant application. In addition to the data results, the project is expected to yield information about ways to improve the survey response rates over time.

The State MH Planning Council has increased its focus on directly contributing to state planning and the State Plan, via collaborating with BBH on two State Transformation measures on youth/young adult transition practices and needs in the public mental health system. Additionally, the Council is receiving direct training on utilizing NH's data from the lead staff conducting the POE project and the IOD-MHSIP survey.

Following the loss of ten inpatient psychiatric beds as a result of the closing of the only Designated Receiving Facility (DRF) in the North Country, Catholic Medical Center closed its psychiatric unit. A plan to secure new inpatient beds in the central part of the state has been unsuccessful. These losses have increased the challenge of the already difficult task of locating or creating additional community-based alternatives to inpatient care at NHH, which continues to sustain resulting increases in admissions to that hospital.

New Hampshire received a National Association of State Mental Health Program Directors (NASMHPD) Technical Assistance Grant for Person Centered Treatment, which is a recovery-oriented model that utilizes shared decision making and client-defined outcomes to help consumers achieve personally meaningful goals. This planning grant is providing technical assistance and training for the staffs of four Community Mental Health Centers.

The Bureau's Office of Consumer and Family Affairs is once again operational, having hired a full time program specialist to direct the Office. The new director is reestablishing the consumer/family and community based connections that had been eroded during a prolonged period of vacancy. The staff is publishing a quarterly newsletter and disseminates e-updates on items of relevance, and has created a Resource Library for public use. The Presidents New Freedom Commission Action Plan continues to be the basis for Person Centered Recovery Based Services and Evidence Based Practice in NH.

"Fulfilling the Promise: Transforming New Hampshire's Mental Health System", a report prepared by the legislated Commission to Develop a Comprehensive State Mental Health Plan has been released, having been in development for two years. BBH administrators and program

staff were, and continue to be, active on the Commission's work teams. The Commission has moved into the implementation phase. Volume I contains the recommendations of the Commission's work and Volume II contains detailed reports from each of the work teams. The reports may be accessed and downloaded at the Endowment for Health website: http://www.endowmentforhealth.org/_docs/126.pdf

A New Hampshire Hospital Taskforce has been established to make recommendations on a 10-year plan to address critical mental health. The report, when released, is anticipated to have a significant impact on state planning for the foreseeable future.

New Hampshire

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

Legislative Initiatives and Changes: Adult System

Changes in the state's governorship and legislature associated with the '04 and '06 elections have resulted in increased governmental attention to the issues of persons with mental illness. Currently the spotlight is on criminal offenders, veterans returning from war, the growing lack of acute psychiatric inpatient beds, the concurrent lack of housing and community supports to enable adults with SMI to remain in or return to their communities, the need to fund mental health on a par with other health care priorities, the need to improve the capacity of the public mental health system, and the need to increase the integration of mental health care with primary medical care.

Chapter 61 of NH laws of 2008: House Bill 740 revised procedures for the revocation of Conditional Discharges including authorizing an Advanced Registered Nurse Practitioner with expertise in psychiatric issues to revoke conditional discharges.

There have been no Medicaid waivers granted for New Hampshire post FY05 that impact mental health services for adults or children.

Summary of Administrative Rules Related to Mental Health:

He-M 305 - The purpose of these rules is to define the circumstances in which, and mechanisms by which, involuntary emergency treatment, seclusion, or restraint can be provided in facilities serving individuals with mental illness. These emergency interventions are designed to be effective, safe, and time-limited and utilized only after all less restrictive options have been exhausted.

He-M 306 - The purpose of these rules is to establish procedures by which an individual involuntarily admitted to New Hampshire hospital has emergency treatment authorized when he or she has been determined to lack the capacity to make an informed treatment decision.

He-M 426 - This rule is being revised to conform to new regulations promulgated by the Center for Medicaid and Medicare Services for Targeted Case Management (TCM). Changes under 426 will also provide more flexibility in where certain IROS services are delivered.

New Hampshire

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Description of Regional Resources: Adult System

New Hampshire's Community Mental Health Centers are private, non-profit, full service clinics, which offer a wide variety of programs. Each of the ten CMHCs serves individuals and families with behavioral health care needs, including access to public mental health services in their communities. Mental health professionals provide treatment and support services to eligible adults and children, either directly or through subcontract agreements. Services include:

- Evaluation and assessment
- Emergency and crisis services
- Individual, family, and group therapy
- Medication monitoring
- Psychiatric evaluations
- Case management
- Symptom management services
- Family support

CMHCs provide special intensive services to persons who meet the BBH eligibility requirements by having a severe mental illness or emotional disability. These services are defined in Administrative Rule He-M 426. The CMHCs are the statewide mainstay for these services, funded primarily by Medicaid and general state funds. Contracts with BBH include quantitative and qualitative performance requirements. When care cannot be provided in the community setting, each center serves as the primary gatekeeper for regional admissions to NHH and other public inpatient psychiatric facilities.

Each of the ten Community Mental Health Centers has an older adult's coordinator and a program of older adult services that emphasize outreach and supports in natural environments including consultation and services to residents of nursing homes. The continuum of services varies depending on the needs of each region and includes intake and assessment, psychiatric services, outpatient services, PASARR reviews, emergency services, case management, outreach, residential services, and peer support.

Regional mental health planning is required by Administrative Rule for adult and children's services, including services designed for older adults with serious mental illness (SMI), age 60 and older. The planning process in each region involves multiple local and state-level agencies, schools, other stakeholders, and consumer of public mental health services and their family members. Regional plans are submitted annually and contribute to state-level planning.

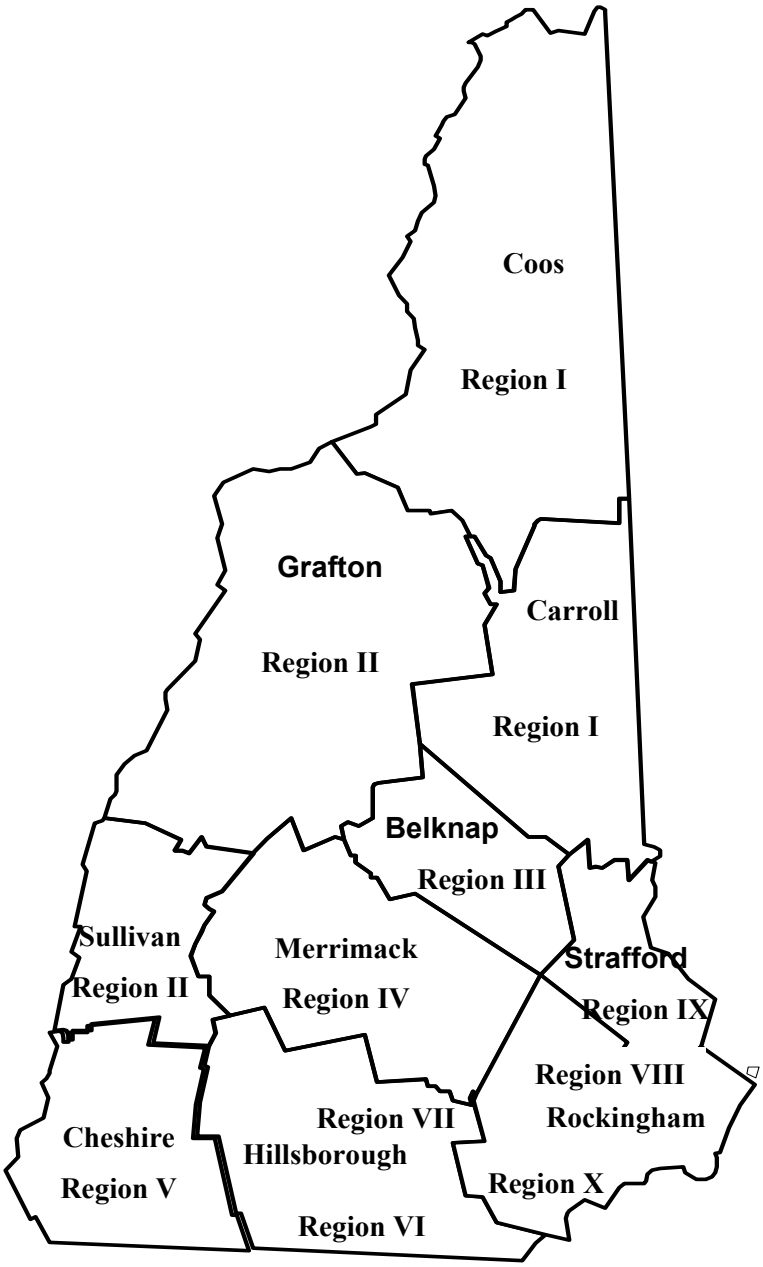
Peer Support Agencies are regional resources for individuals seeking support for their recovery outside of, or in addition to, clinical services. New Hampshire's MH system offers one Crisis Respite program for adults that is consumer-run. The PSA Stepping Stone provides the Stepping Stone Crisis Respite program, a 24-hour, short-term, non-medical program designed to be an alternative to psychiatric hospitalization. Located in Claremont, it is available to any person in the State of New Hampshire who has a mental illness and who uses publicly funded mental health services or is at risk of using publicly funded mental health services. Funding is available for transportation to and from the program, to assure statewide access.

Additional resources available to the public include a statewide system of Area Agencies for Developmental Services and DHHS District Offices. The District Offices handle eligibility determinations for child care, child support, child protection, nursing home care, long term care, elderly and disabled Supports, financial assistance, food & nutrition, foster care & adoption, juvenile justice, Medicaid and other medical assistance programs. Alcohol, Tobacco, and Other Drug prevention and treatment programs are available to all regions. There are also regional Public Health Networks, local Health Officers, and town and county-specific local resources.

Community Health Centers (CHCs) provide comprehensive primary and preventive medical and dental health care delivery. CHCs are owned and operated by the community, and serve everyone regardless of their ability to pay. CHCs provide immunizations, prenatal care, maternal and child health services, cancer and other preventive health screenings, preventive dental care, chronic disease management and free and reduced cost prescription drug services to vulnerable people and their communities.

Below is a map of New Hampshire's Counties and Community Mental Health Service Regions. In addition to the Community Mental Health Centers in each region, nine of the ten regions also have a Peer Support Agency, many with Peer Support satellite offices in other parts of the region. Region VI is in year one of establishing a PSA for that area.

New Hampshire Counties and Community Mental Health Service Regions



NH population: 1,309,940 (2006)

Consumers receiving publicly funded mental health services in community mental health settings: 46,909, or 3.6 % of the population is served in the public mental health system. Mental illness prevalence is estimated at approximately 5.4% of the population.

New Hampshire

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Description of State Agency's Leadership: Adult System

The Bureau of Behavioral Health seeks to promote respect, recovery, and full inclusion for adults who experience a serious mental illness and for children with a serious emotional disturbance. BBH works within the broader system to fulfill the mission that the Department of Health and Human Services promulgated in 1995: to join communities and families in providing opportunities for citizens to achieve health and independence.

BBH's mission is to continuously improve an effective, efficient, and accessible system of community mental health services and supports for State-eligible individuals. BBH strives to conduct public mental health system transformation activities in New Hampshire in accordance with the President's New Freedom Commission goals and recommendations.

BBH maintains authority over Community Mental Health Center (CMHC) administrative rules while working collaboratively with the Department to develop such administrative rules in conformance with existing rules and program intent. Regular and as-needed meetings of the CMHC Medical Directors and the BBH Medical Director are held to coordinate medical and psychiatric services across CMHCs and to address emergent issues and difficulties.

The leadership role of BBH is exemplified by staff presence, consultation, and participation on key committees, task forces, and coalitions, via the trainings offered to providers and stakeholders statewide, and by the provision of data and reports on a variety of mental health subjects for both interagency and public use. Some of these activities and groups include:

The BBH administrator serves on numerous state level policy making or policy influencing groups, including ongoing groups associated with the Commission to Develop a Comprehensive State Mental Health Plan (the Mental Health Commission), the NH Emergency Shelter and Homeless Coordination Commission, Interagency Council to End Homelessness, Commissioners Adoption Task Force, the Governor's Commission Prevention Task Force, and the NHH Task Force for a 10 Year Plan, among others.

Bureau staff serve on many interagency groups, Councils, task forces, and committees as knowledgeable consultants for the mental health system. Just a very few examples include: The TANF Hardship Committee; the Medical Care Advisory Committee; Legislative Task Force on Deaf and Hard of Hearing; the Coalition on Substance Abuse and Aging; the State Mental Health Planning and Advisory Council; the mental Health and Aging Consumer Council, the NH Consumer Council, the Suicide Prevention Council, and local District Court stakeholder groups.

New Hampshire

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Overview of the State's Mental Health System: Children's System

This is a joint response. See Adult Plan for comprehensive overview of both systems. Additional detail on the children's system is below.

Under RSA 135-C, the enabling legislation for the Bureau of Behavioral Health (BBH), children's eligibility for services is to be determined only after consideration of the requirements under RSA 169-B, C & D and 186-C. These RSAs specify the responsibility of child protection, juvenile justice, and special education to serve the mental health needs of children in their care.

These RSAs also specify the availability of New Hampshire Hospital (NHH) and Community Mental Health Centers (CMHCs) as providers of services through the courts. The provision of optional mental health services without eligibility requirements is encouraged under the enabling legislation. New Hampshire has a long history of commitment to children's inpatient and outpatient services.

At each of the Community Mental Health Centers there is a designated Children's Director. The children's directors meet on a monthly basis with the BBH children's administrator and representatives from NAMI NH and the Granite State Federation of Families for Children's Mental Health, Division for Children Youth and Families (child protection agency) and others as appropriate to the agenda. This group works as a collaborative network for shared learning and input into program planning, administration and policy development.

Resources and responsibility for children's mental health services are by statute spread across five public entities:

- Bureau of Behavioral Health: RSA 135C (Designates and approves local mental health programs through the CMHCs)
- Division for Juvenile Justice Services (DJJS): RSA 169-B and RSA 169-D
- Division for Children, Youth and Families (DCYF): RSA 169-C
- Special Medical Services (SMS): RSA 132-13
- Special Education through local School Administrative Units (SAU): RSA 186-C

These five entities with families and youth are required partners in conducting ongoing planning for regional children's mental health programs. It should also be noted that in NH the counties are required to pay 25% of the cost of mental health services ordered through the district courts for youth with a legal relationship with Child Protection or Juvenile Justice.

New Hampshire

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

Summary of Areas Previously Identified by State as Needing Attention: Children's System

The children's Statewide Individualized Resiliency and Recovery Oriented Services/Evidence-Based Practices (IROS/EBP) steering committee did a significant amount of work helping to draft the new Administrative Rule He-M 426, which needed attention to insure that its service descriptions and language were age and developmentally appropriate, as well as supportive of a resiliency/recovery oriented framework. IROS also provides for Functional Support Services that include Medication Education, Symptom Management, Family Support, and Therapeutic Behavioral Services.

Additionally, the children's IROS/EBP group worked on the content of a set of basic Foundation Skills trainings to ensure that the trainings were relevant to the children's workforce. This series of foundational skills training for CMHC staff, especially paraprofessionals, is also open to interested consumers and family members, through the various MH Councils. The delivery of the Foundation Skills training helps strengthen the basic competencies for the children's system work force and provides a platform for the introduction of EBPs.

The children's service system has made progress in both planning for the development of EBPs and in implementation of Trauma-Focused Cognitive Behavioral Therapy (TFCBT). The Dartmouth Trauma Research Center, in partnership with West Central Behavioral Health, a CMHC, and the Bureau of Behavioral Health, applied to the National Child Traumatic Stress Network for the Partners in Adolescent Trauma Treatment project (PATT). PATT is implementing the TFCBT practice.

The NH Endowment for Health awarded a planning grant for teleconferencing infrastructure development with the CMHC system and Dartmouth. Other funding from a private foundation along with local CMHC funding resulted in all ten CMHC's having teleconferencing equipment. This technology was used for the expansion of the TFCBT practice to all ten CMHCs, which is a continuing EBP.

The Bureau has established a mechanism (billing, clinical protocols, consent protocols) for services to be Medicaid reimbursable if provided by video conferencing. Currently, Northern Human Services (Region I, in the most rural northern part of the state) is utilizing video conferencing to provide access to child psychiatry for the first time to its clients.

Two additional areas needing attention, and the accomplishments, are school-based mental health services and Integrated Children's Services.

Mental Health and Schools: BBH has been partnering with the NH DOE project to develop Positive Behavioral Interventions and Supports (PBIS) infrastructures in NH schools. Many of NH schools have implemented PBIS. Using the three tiered PBIS model of universal, targeted and intensive level interventions linkages are being made to PBIS schools by CMHC's and other community entities in some regions of the state through a federal Safe and Drug Free Schools grant initiative. This project has accomplished cross training and the creation of community–based collaboratives in some these regions. BBH remains involved in a number of activities to promote school-based and school connected MH activities**.**

Integrated Children's Services: BBH continues to recognize that funding and responsibility for mental health services is spread across a number of agencies. Integrated children's services are a priority in New Hampshire's State Plan. The increased focus on improving the children's mental health Regional Planning process is creating better linkages among families, CMHCs, Juvenile Justice, Child Protection and Public Health providers in the regions. Additionally, the state has embarked on a project for Integrated Children's Services with a plan to use an Administrative Services Organization strategy to braid financing and develop care management processes for youth with intensive service needs and their families.

New Hampshire

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

New Developments and Issues: Children's System

Unfortunately, the newest development in Children and Adolescents Mental Health Services is the vacant and "frozen" position of the state planner that coordinates the services in collaboration with other child/youth-serving agencies. The former coordinator retired in 2007. The State agencies have since been under a hiring freeze. A special waiver to fill the position has been requested, but has not yet been granted. The position is at risk for being abolished if it remains vacant for an extended period of time, which is a kind of "Catch 22" situation. In the interim, the administrator for the Community Services Program Unit is handling the essential interactions required to maintain operations, and all the interagency teams that support the children's system continue to meet, with the ongoing goal of expanding effective integrated services.

This year the Endowment for Health, with partial funding from the MH block grant, is implementing Project RENEW at three mental health centers and the Tobey School. The Tobey School is an alternative day and residential school for students identified as educationally disabled and entitled to services under an Individual Education Plan (IEP). Project RENEW is a school-to-career model for youth with SED.

Another new development is the lack, to date, of any submissions of proposals for the Child ACT contract, which was ideally to have begun by July 2008. The Bureau is hopeful there may still be a contract awarded resulting in the program implementation in FY09. This EBP is New Hampshire's first reportable program per the block grant Guidance for the NOMS. The other EBP for children that NH conducts is Trauma-Focused Cognitive Behavioral Therapy (TFCBT).

New Hampshire

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

Legislative Initiatives and Changes: Children's System

This is a joint response. See Adult Plan. There are no significant legislative initiatives specific to children's mental health in the last year.

Of interest, House Bill 537, requested by the Department of Health and Human Services- was enacted, establishing a task force on homeless teenagers. See Child Plan Part C, Section III, Criterion 4: Outreach to Homeless for expanded information.

New Hampshire

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

Description of Regional Resources: Children's System

This is a joint response. See the Adult Plan for resources also available to the child population. In addition, see Child Plan Part C, Section III, Criterion 3: System of Integrated Services

New Hampshire

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Description of State Agency's Leadership: Children's System

This is a joint response. The description in the Adult Plan applies to children's services as well.

BBH takes advantage of the small size of the state to participate in the coordination and leveraging of resources. BBH works collaboratively with child-serving agencies on a regular basis, in multiple venues for planning and program development activities. In addition to family agencies, key partners include child protection, juvenile justice, education, health (including special medical services and maternal and child health). Examples include: the Integrated Children's Services planning team, the Children's EBP Steering Committee, CMHC Children's Directors meetings, the Community of Practice for Transition, the Infant Mental Health Team, as well as grant funded initiatives.

Currently the Bureau's representation has been scaled back, due to the extended vacancy in the Children's Services coordinator position. That position is crucial to BBH leadership within the various children's systems. A waiver to fill the position on an expedited basis has been re-submitted. The Bureau has a strong commitment to the integration of children services.

New Hampshire

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

Service System's Strengths and Weaknesses: Adult System

New Hampshire is "the Granite State" and the State motto is "Live Free or Die". These few words capture the rock-solid, tenacious, independent, and spirited character of the majority of those involved with the mental health system. The system is not without vulnerabilities of course, which will be discussed later in this section, but it is a system primarily of strengths. Among the most important strengths of this system are these:

- Continuous quality improvement activities
- Continual updating and upgrading of data information systems
- Commitment to establishing, maintaining, and expanding Evidence-Based Practices
- Fiscal soundness and accountability
- Attention to necessary revisions to Administrative Rules governing the mental health system
- Inclusion of consumers, family members, and interested others in the planning process
- A determination among all stakeholders to regain ground lost over the years, by identifying and implementing the best research-to-practice modalities available within the fiscal realities.

The CMHCs in NH put a high degree of effort, often uncompensated, into providing comprehensive, evidence-informed, outpatient services for children, adults, and older adults. They work with the SMHA and other providers and agencies to maintain the essential continuum of care among multiple systems, including inpatient care, nursing home level of care, housing programs, programs for special populations, services to rural communities, the justice system, the school system, and growing private-public partnerships involving primary health care.

As with many, if not most, public mental health systems in the nation, NH is experiencing a period of economic difficulty, with many impacting factors far beyond the scope of the State budget for mental health services. The system's strengths are being challenged further.

"New Hampshire's mental health system... (is) at risk. In the past 10 years, admissions to the state's public psychiatric hospital have doubled. Local communities have seen reductions in psychiatric hospital units, group homes that provide residential treatment, and intensive outpatient services. Per capita expenditures at the state's mental health centers have been reduced by nearly half. Primary care providers have seen significant increases in mental health issues in their medical settings. The rate of incarceration for people with mental health issues has risen." Transforming the Mental Health System, Report of the Mental Health Commission, 2008.

The CEO of one of NH's larger CMHCs noted in a recent newspaper article that "...it is not just the governor's...budget cuts, but a combination of new federal rules, state revenue shortfalls, and increased limits on insurance and Medicaid benefits that have created this perfect storm. While this is bad news for this year, what it portends for the future is much worse." The article

identifies several trends perceived as having an undesirable affect on the CMHCs, which in turn contributes to challenges throughout the system.

"The Changing Dynamics of Hospital Care for Mental Illness & Substance Use in New Hampshire – Implications for Supporting Continuums of Care," is a new policy brief from the University of New Hampshire's Institute on Disability. Findings indicate that "...although demand for hospital services among people with mental illness or substance use conditions is rising, services to treat and pay for such care may not be keeping pace. Researchers reviewed 1997-2006 New Hampshire ambulatory, inpatient, and specialty hospital records involving patients presenting either mental illness or substance use conditions." Some of the findings are worth noting here, as they have direct implications for the state-funded community-based system. The report may be accessed at http://www.iod.unh.edu/accessnh.html

♦ Demand for emergency department and ambulatory care among people with mental illness or substance abuse conditions is rising, particularly among younger residents. Between 1997 and 2006, mental illness hospitalizations increased 55 percent among 15 – 29 year-olds.

♦ Private insurance is less likely to pay for the care of people with mental illness or substance use conditions. For patients who are repeatedly hospitalized, private insurance is no longer the majority payor source.

♦ There are no inpatient (acute care) medical facilities with dedicated resources for the integrated treatment of mental illness or substance use conditions in key areas of New Hampshire. Many towns in the North Country as well as in central and eastern New Hampshire rank in the top 20 percent of towns with the highest rates of hospitalization for mental illness or substance use but have no acute care medical facilities to provide resources dedicated to these issues.

♦ Among patients who are frequently hospitalized (at least 10 times over 10 years) with a primary condition of mental illness, 75 percent had a co-occurring diagnosis of substance use in a quarter of their visits, accounting for a disproportionate share of charges.

New Hampshire

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Unmet Service Needs: Adult System

The areas previously identified as needing attention naturally incorporate unmet service needs and gaps in the system. Some of the key issues that render the system less than optimal are:

1. HOUSING: The lack of available, affordable housing, the housing stock shortage, an insufficient number of transitional housing beds, and a lack of supported permanent housing are severe problems in the state. People must stay longer than desired in both the hospital and the transitional settings due to the lack of housing. According to the 2007 Emergency Shelter and Homeless Coordination Commission Annual Report, NH had a statewide rental vacancy rate of 3.4%. (2% is considered equal to "no vacancy"). In addition to the lack of available units, those offered at Fair Market Rental (FMR) are exceptionally scarce. Section 8 housing vouchers are in limited supply, with wait lists of several years. The report notes that for the last 10 years, the average percentage increase for rental housing has been double that of SSI. The average rent for a one-bedroom unit in NH is 119% of SSI income. For adults with SMI who have low incomes, access to adequate and affordable housing is a most serious barrier to maintaining their lives in the community.

2. COMMUNITY SUPPORTS: The need for additional community supports to prevent hospitalization, is highlighted in "HELP NEEDED: Emergency Mental Health Care in New Hampshire's Rural Hospitals" (2007 report prepared for the Rural Health Coalition). Cross-cutting concerns of the communities are: lack of in-patient resources in rural areas; few community treatment resources for persons with low income; lack of clarity regarding the involuntary emergency admission process; inadequate number of mental health professionals located in rural areas; (and) problems obtaining transportation to treatment.

3. WORKFORCE: Workforce training, recruitment, and retention have long been problematic and as the mental health workforce ages and is reaching retirement, fewer younger practitioners are entering the public sector. CMHCs find that maintaining competitive salaries is difficult. Cross training in multiple disciplines is difficult to attain due to a lack of curricula in higher educational settings, further contributing to workforce development issues for the mental health system. New Hampshire's workforce shortages include primary care health professionals, dental health professionals, and mental health professionals. Shortages in psychiatry are prevalent. Workforce challenges regarding respite care, primary medical care, and mental health care are expected to increase and have a significant impact on the services for all consumers and their families, across the lifespan. The rural areas have particular difficulties attracting workers.

4. CRISIS BEDS IN COMMUNITY HOSPITALS: There is a need for sufficient psychiatric beds in the community and the lack of crisis beds in community hospitals is affecting the rate of readmissions at New Hampshire Hospital, which has not seen a decrease in the rate in over nine years (Vermont Mental Health Performance Indicator Project "Convergence in State Hospital Utilization Rates in the Northeast", John Pandiani and Brendan Martin, June 2008.) Ten years ago NH's general hospitals had 108 inpatient psychiatric beds; currently there are eight. (Erik Riera, Bureau Chief, BBH, 2008)

5. SPECIAL POPULATIONS: Needs affecting special populations include transportation, gaps in adequacy, availability and access for rural residents and elders, the lack of effective transition protocols for youth and young adults moving into the adult mental health system, and the need for medical and mental health trained interpreters for foreign language minority and refugee populations. There is only one CMHC in the largest rural area, which must serve seven hospitals in three counties. If the center has only one psychiatrist or crisis worker on call, there may be multiple delays if several community hospitals have people presenting with psychiatric emergencies.

6. PEER SUPPORT NETWORK: New Hampshire's eight Peer Support Agencies operating under contracts with the Bureau of Behavioral Health have not been reviewed in several years and are due for certain monitoring and evaluation Quality Improvement activities. Services statewide are highly variable, and some PSAs appear to be in need of increased technical assistance in order to meet the financial performance obligations as well as the minimum data reporting requirements needed for BBH reporting and planning. A ninth PSA in under development, which will result in all regions having independent peer support services available.

New Hampshire

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

Plans to Address Unmet Needs: Adult System

To develop the State Plan, in addition to internal data and reports, BBH utilizes information and reports from entities such as the New Hampshire Hospital Task Force, the New Hampshire Center for Public Policy, the Institute on Disability at UNH, the Disability Rights Center, NAMI-NH, the Mental Health Commission, the NH Comprehensive Healthcare Information System, and many other data sources, including the federal resources for mental health care data and policy development.

Each of the block grant's five criteria and the associated measures and indicators (NOMS) directly links to the planned activities of the NH community mental health system, including those targeted to confront the challenges of housing, community supports, workforce development, hospital crisis beds, special populations, and peer support.

These plans are ongoing, and included in BBH contract language, administrative rules governing the service array required of the CMHCs, and monitored through Quality Improvement activities and data submissions, required as part of the contracts. Continuation and enhancement of key strategies are priorities for the FY08-FY10 performance period.

To maintain the current level of services and make progress on reducing unmet needs, BBH identified a number of priorities, based on available data that are ongoing:

- Review and revise state Administrative Rules, as needed.
- Develop contracts based on benchmarks and performance indicators.
- Streamline data collection and improve the MHSIP consumer survey process.
- Revise reimbursement methodology based on the cost of providing services.
- Increase community-based supports to help prevent hospitalizations and enable people to return to residence in their communities.
- Promote resiliency and recovery through consumer choice.
- Implement evidence-based practices.
- Establish Integrated Children's Services.
- Increase support for the State MH Planning Council and other groups, to increase the involvement of consumers and their families in the planning process.
- Support efforts to implement mental health courts at the District Court Level.
- Support and provide education to judiciary, correctional and law enforcement personnel.

BBH set new budgetary priorities for the FY08-FY09 biennium that addresses some of the unmet needs identified, and which include the following significant commitments:

1. Community Residence Rate Increase: The day rate for certified community residences is currently $81.00 a day. The cost to provide these services is estimated at $107.00 per day. The rate will be increased to $94.00 a day in FY 08 and $107.00 per day in FY 09. This priority will help support the continued availability of these residences.
2. Residence, Education, Assistance and Prevention: Additional funding will be made available to expand REAP services. This priority provides outreach to at-risk seniors who are not connected with mental health and/or substance abuse services in the community.

3. Funds for Medicaid Services: BBH has received sufficient funding to pay providers for Medicaid services based on projected enrollment, and utilization levels anticipated for FY 08/09.
4. New intensive treatment teams: In FY08, funding was made available to establish an Assertive Community Treatment team to provide intensive, community based services for adults with SMI. An ACT team for children with SED will be funded in FY09.

New Hampshire

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Recent Significant Achievements: Adult System

Funding has been made available to initiate the state's first Assertive Community Treatment team that will be reported on via a performance measure. The ACT team is located in Nashua, a densely populated urban area. The team provides extended hours of services, weekend services and emergency services by team members. Clinicians have small caseloads of 10-15 clients.

The Bureau is strengthening what has been a modest Quality Improvement (QI) team by assigning additional staff to the team. The expansion will enable a greater emphasis on system transformation and continuous quality improvement. Of significance, the Peer Support Agencies had not been reviewed in several years. A new review instrument has been developed and site reviews to all centers, including the satellite sites, will begin in August 2008, following training in the use of the instrument for both the review team and the agency directors. The State Planner is on the QI team for the PSA reviews, as a significant portion of the block grant allocations are dedicated to the peer support initiatives. The Peer Support Agencies are also involved in creating a new State performance measure related to soliciting feedback from the members and participants of the centers statewide.

BBH is also participating in the SOAR Initiative (Social Security Outreach, Access and Recovery). Focusing on individuals at risk of homelessness this model trains advocates on how to complete the entire application process to improve overall outcomes including benefits, housing and return to work. This is managed by BHH. NH was selected as one of ten states to receive the technical assistance to implement SOAR.

The Bureau of Behavioral health is monitoring services to BBH consumers, including medication use, through Medicaid claims databases. This information will be used to conduct a preliminary evaluation of prescription practices in the state and will provide information regarding the need for interventions to enhance best practices in pharmacotherapy.

The recently reactivated Office of Consumer and Family Affairs' new initiatives include:

♦ Dissemination of information to consumers & families: Quarterly newsletters that feature articles written by consumers, information on supported employment, rule changes, updates of the State MH Planning Council, and descriptions of various new initiatives; distribution of materials to various other councils, Peer Support Agencies, NHH and community groups.
♦ OCFA e-newsflashes - immediate dissemination of important, time-sensitive information.
♦ Resource Library - free pamphlets, books on loan, and computer web access; print materials are also available for the State Planning Council that may have been sent electronically.
♦ Training and education: an Empowerment Through Information Workshop was attended by 80 consumers and families, and received highly favorable comments; provision of technical assistance in developing goals and objectives
♦ Person-Centered Treatment Planning discussions are being held at Peer Support Centers
♦ The OCFA director acts as a liaison to the BBH director, bringing consumer/family issues back from throughout the state, while developing linkages and collaboration, including membership on mental health councils and visits to Peer Support Agencies statewide

♦ Other activities include identifying leaders for future leadership training, identifying consumer/family needs for a future conference; meetings with executive directors of the CMHCs

Funding through the Family Mutual Support Grant was awarded to NAMI NH to provide family support, education and leadership development for families across the life span, as well as, an anti stigma campaign and public education programs. Additionally, funding through a BBH grant was awarded to NAMI NH to provide transitional planning process education and support for adolescents/young adults with mental illness and their families. Through this grant, NAMI NH. in partnership with the Parent Information Center, provides the following supports/programs:

♦ A Transitional Mentor is working with those who have been patients at New Hampshire to develop a Future's Plan
♦ A one day conference will be held on the Transition Planning Process for this population and their families
♦ "Life After High School" is a program for this population and their families that includes school staff and community agency providers.

Finally, both the Mental Health and Aging Advisory Council and the Mental Health Consumer Council, with technical assistance from the Office of Consumer and Family Affairs on setting goals and objectives, are being revitalized and are expected to increase their input to the Bureau for the purpose of the state planning process from the consumer-family perspective.

New Hampshire

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

State's Vision for the Future: Adult System

The Bureau of Behavioral Health's vision for the future is succinctly outlined in excerpts from a presentation by Bureau Administrator Erik G. Riera to New Hampshire's Executive Council. The education of the Council is important for state planning initiatives. Per the government web page at http://www.nh.gov/council/index.html:

The Executive Council of the State of New Hampshire has the authority and responsibility, together with the Governor, over the administration of the affairs of the State as defined in the New Hampshire Constitution, the New Hampshire statutes, and the advisory opinions of the New Hampshire Supreme Court and the Attorney General. Each of the five Executive Councilors represents one fifth of the population or approximately 247,000 citizens. Councilors are elected every two years, concurrently with the Governor.

The Councilors participate in the active management of the business of the state. All state departments and Agencies must seek approval of both receipt and expenditures of state and federal funds, budgetary transfers within the department and all contracts with a value of $5,000 or more. Councilors are elected to serve as advocates for the people.

Excerpts from the Bureau's presentation to the Executive Council follow:

Change Initiative: Charting a New Course for Mental Health Services

MH Commission
- Established under HB 691
- Report has been issued

NHH Taskforce
- Established to make recommendations on a 10-year plan to address critical mental health service system improvements
- Report to be issued

Change initiative: Best Practice Service Model

Implement best practice, or Evidence Based Treatment in NH
Goal:
Consumers have access to treatment demonstrated most effective at promoting recovery from mental illness
- Programs implemented or in process of implementation
  - Illness Management and Recovery
  - Supported Employment
  - Partners in Adolescent Trauma Treatment (PATT)
  - Assertive Community Treatment (ACT)
  - Integrated Illness Management and Recovery Pilot (I-IMR)

Change initiative: Advanced Video Conferencing

Implementation of Video Conferencing as a new mental health service delivery model in NH
Goal:

- Increase access to services, particularly resources in short supply like child psychiatry
- Increase available time of clinician's for community based work
- Decrease wait time for services
- Expand availability of Emergency Services evaluations to local hospitals

Change initiative: Expand Impatient Bed Capacity

Expand Inpatient Psychiatric Bed capacity in NH's general hospitals to replace beds lost over the last 10 years for involuntary emergency care (from 108 to a current of 8)

This year alone, NH lost the only unit providing these services for the North Country
Goal:
Consumers will have access on a local level to critical inpatient psychiatric care, and address critical bed shortages at New Hampshire Hospital

Currently working with a central NH Hospital to establish a new 10-bed unit scheduled to open in July (Update: this contract did not materialize.)

Change initiative: Increase Consumer Involvement in Treatment

Consumers will play a greater role in the treatment planning process and directing their care
Goals include:

- Improved outcomes
- Greater satisfaction with services
- NH was awarded a technical assistance grant, and will be training Community Mental Health providers and consumers starting this spring.
- Added Peer Support to Nashua region
- BBH contracts with NAMI for a number of programs to assist consumers and families
- Re-established the Office of Consumer and Family Affairs after a long period of vacancy

Change initiative: Monitoring and Reporting on Outcomes

Improve data collection from community providers and other state agencies
Goal:

- Demonstrate the effectiveness of services
- Monitor the efficiency of the service delivery system
- Identify opportunities for improvement

Implementation of a new statistical information system- Phoenix
Measure satisfaction with services
Exploring the implementation of an Electronic Health Record
Development of standardized outcomes measures

New Hampshire's vision for the future is to transform the service delivery system to one based on resiliency and recovery oriented services, set on a foundation of evidence-based practices.

New Hampshire

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

Service System Strengths and Weaknesses: Children's System

This is a joint response. See the Adult Plan for strengths and weaknesses that impact both systems. Additional information on the children's system is below.

NH has children's mental health system that is attempting to meet the increasing demand for services over the last 13 years. In FY07, 11,735 children were served. Of these, 8,028 were State-eligible children with SED, or over 68% of those served. By contrast, in 1995, 6409 children and adolescents were served by the CMHCs.

NH estimates that approximately 5% or 30,000 youth have SED. Federal prevalence estimates for SED are 5-9% nationwide and are in the process of being updated. The penetration rate for the children's programs in NH are 27% for eligible youth and 39% for all children served. We know that some youth with SED who are involved with child protection and juvenile justice see mental health providers other than CMHCs and some are served in the private sector. We do not have these data and cannot estimate unmet need for service access.

The children's programs at the CMHCs have strong leadership. The children's directors form a dedicated and creative network that collaborates on planning, program development, and quality improvement activities. Due to the increasing service demand and the lack of growth in funding, CMHCs are required to do more with less. This requires a focus on billable hours and revenue generation that impacts their ability to meet the need for a high level of collaboration and coordination with families, schools and other entities.

Staff time away from billable activities, such as time for supervision, education and training, regional planning, as well as some service coordination and/or support activities is at a premium. These demands, as well as relatively low staff salaries, contribute to the difficult recruitment and retention problems that the CMHC children's programs face. CMHCs periodically have waiting lists for access to services other than emergency/crisis services. Some members on the Planning Council have noted that these wait times are often lengthy and frustrating for the families. To date there is no standardized data collection mechanism to provide specific information on the wait times at the different centers and identifiable reasons.

Legal and financing responsibility for children's mental health services is spread across a number of child-serving agencies. Services and financing are fragmented so that service access for families with intensive service needs who are multi-agency-involved is very difficult. Varying eligibility ages and criteria between and among multiple child and adult systems that serve youth and young adults with serious mental health challenges is a significant weakness of the present system overall. Removing the financial and other barriers to the provision of integrated services would improve the CMHCs ability to coordinate children's mental health services.

In spite of these challenges, providers of services for children with mental health needs are working toward a higher degree of collaboration and integration with their communities, including families, special education, child protection, juvenile justice and, increasingly, public and private healthcare providers.

New Hampshire

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Unmet Service Needs: Children's System

This is a joint response. Some the unmet service needs discussed in the Adult Plan are applicable for both systems. Additional information on the children's system is below.

The children's systems' most pressing needs parallel the adult system in the area's of community crisis response to prevent hospitalization, workforce development, services to special populations (such as youth with developmental disability/mental illness, sexually reactive youth, and youth dually diagnosed with MI/SA). Additionally, youth transitioning to adulthood and moving between child and adult systems of care have been identified as an underserved population. These needs are documented through a multi-year analysis of children's Regional Plans for the past several years and continuing. We do not have quantitative data on the number of youth that fit in these populations. All of these needs translate to the need for increased funding.

Of interest, major findings from "Mental Health Services for NH's Children" indicate that 25% of children enrolled in NH Medicaid access services for a mental illness, comprising more than half of the total medical expenditures for children. In 2005 this was 17,600 children. The majority of the mental health expenditures are for children enrolled via Temporary Aid to Needy Families (TANF). The report notes that the public mental health provider system is made up of three primary systems: the community mental health centers, the public school system, and therapeutic foster care providers. The costs for services are 74% ($60 million) of total MH expenditures.

The report goes on to note that "The lack of data regarding service use and diagnostic information-particularly for the services provided through the schools-is of some concern." Half of the Medicaid expenditures data was missing diagnoses, making it difficult to explore the reasons for these children to seek care. Without this information one cannot determine which mental illnesses are truly driving costs. Policymakers and providers are hindered in creating and implementing effective services for children in the public system. Analysis of the mental health needs and service use patterns of the TANF population would be a place to start in order to understand the underlying drivers of these MH expenditures within Medicaid.

Neither pharmaceutical nor dental expenditures were included in the analysis. After finding expenditures in the private sector and the hospitals to be a relatively small amount for children, the report notes that "Services for children's mental health are clearly a driver of costs in the public healthcare system." The report, by Steve Norton and Ryan Tappin, is published by the NH Center of Public Policy Studies (9/07) and is available at www.nhpolicy.org

New Hampshire

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Plans to Address Unmet Needs: Children's System

This is a joint response. See the Adult Plan. Additional children's system material is below.

Specific to children, there is a budgeted plan to develop one community-based 24/7 intensive services team (a modified ACT) to reduce the need for hospitalization and support community tenure. An RFP for the children's ACT was released in May 2008.

BBH is using training and education to impact workforce development issues. In addition to the series of basic skills training (Foundation Skills Training) that is being provided to the general CMHC workforce the children's system is on an aggressive plan to introduce evidence-based practices to the workforce, utilizing a statewide videoconferencing infrastructure that includes the Dartmouth Trauma Research Center and the ten CMHC children's programs. The first EBP is Trauma-Focused Cognitive Behavioral Therapy (TFCBT). The TFCBT practice is funded by SAMHSA through the National Child Traumatic Stress Network (NCTSN).

Plans to introduce up to three new EBPs over the next three years have been funded by the NH Endowment for Health, a private foundation, for $150,000 for each of three years. The virtual training unit utilizing the videoconferencing infrastructure for training, supervision and consultation is in place.

BBH is normally a participant in a statewide Community of Practice (CoP) focused on transition and supported by the National IDEA partnership. This learning community has broad participation across partners including education, family and youth agencies, MH and others, at both the state and local levels. The State Board of Education has representation in this community as well. Linkages to agency mandates and initiatives are being made. Currently the position responsible for this participation is vacant, limiting the Bureau's level of activity.

As noted in Part C Section I "New Developments", the Endowment for Health, with partial funding from the MH block grant, is implementing Project RENEW, a school-to-career model for youth with SED at four mental health centers and the Tobey School. This will add to the efforts to increase transition-informed services in the children's system.

The Planning Council collaborated with the SMHA to create two shared transformation performance measures for the children's and adult MH systems, to improve transition practices in support of NH's priority populations between ages 14 and 24. The initiative is focused on reducing disparities and ensuring access to appropriate MH services and supports. Work on these measures in collaboration with BBH is expected to be continued for two more years.

BBH revised the regional plan format for the children's system in 2006, which has standardized the content of needs assessment and plans for both CMHCs and their regional partners involving child protection, juvenile justice, special education families and public health providers. This is helping to better articulate the needs of special populations, such as DD/MI, SA/MI, and those with sexually reactive or sexually offending behaviors, as well as transitional-age youth. We will then be better able to develop targeted plans to address their unmet needs, and further leverage the value of regional planning.

New Hampshire

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Recent Significant Achievements: Children's System

Although this is not a joint response, please note that the significant achievement activities described in the Adult Plan may have impact and benefit for families of children with SED, especially the work of the Office of Consumer and Family Affairs.

The improved regional planning process is in its second year and is reinforcing the importance of partnership and shared responsibility for children's mental health with families, and other child-serving entities. The process and a new standardized format for the plans as submitted is helping to better articulate the accomplishments and challenges in the comprehensive system for children and adolescents. This is of help relative to state planning discussions and to inform the State Planning Council.

Other recent achievements include having funds available for a children's ACT, with an RFP released, the increased attention to transitional-age youth, the partial funding of Project RENEW, the EBP Disruptive Behaviors being conducted by the CMHCs, and the programs NAMI-NH is conducting as Family Support Services across the lifespan.

New Hampshire

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

State's Vision for the Future: Children's System

This is a joint response. See Adult Plan for the State's vision for the future of both systems. Additional information on the children's system is below.

The vision for the future for the children's system is twofold: First, the goal is to increase the community-based service and support capacity at the CMHCs to better maintain community tenure, avoid hospital and out of community residential services, and promote positive home, school and community outcomes for the priority population of youth with SED. Second, to work with families and systems partners to leverage shared resources, and increase care access and coordination, within a comprehensive, integrated system for youth with the most intensive service needs, who are interagency-involved.

We expect that both outcomes will be achieved over time and be supported through a process of ongoing regional planning and needs assessment. Planning and assessment shall be fully inclusive of families and youth, and key partners in child protection, juvenile justice, special and general education, and public health. Information from regional planning will inform both budget development for service capacity expansion at CMHCs, and the identification of local needs and strategies that align care access, care management activities, and resources, within a comprehensive integrated children's services system. Developing processes to increase the involvement of the youth "voice" in planning is a priority.

The vision for integrated children's services is built on the premise that for children and youth with mental health challenges, it should not matter through which "door" they enter the system. Whether children and youth enter through child protection, juvenile justice, special education or public mental health systems they should have access to quality, affordable, traditional and non-traditional mental health services that will support them in their communities. The financial and other barriers that affect service access require increased intra-agency agreements to be reduced or removed from the multiple systems serving children and youth with mental health challenges.

New Hampshire

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Establishment of System of Care

New Hampshire law under Chapter 135-C establishes the state's mental health services system. Any city, county, town, or nonprofit corporation may establish and administer a community mental health program for the purpose of providing mental health services to individuals and organizations in the area. The state contracts with community mental health centers throughout the state, one in each of ten designated mental health service regions. See Part C. Section I. Description of Regional Resources, Fig. 1 for a map of the regions.

Every program shall, at a minimum, provide emergency, medical or psychiatric screening and evaluation, case management, and psychotherapy services. The department may contract with a community mental health program, pursuant to RSA 135-C:3, for the operation and administration of any services that are part of the state mental health services system. The Bureau continually reviews and revises the Administrative Rules, which specify the standards of care for the operations of providers of state-funded community mental health services.

New Hampshire

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Available Services: Adult System

The service array described in the document below is drawn from the BBH billing categories and service descriptions and is a part of the contracting process. This document will be undergoing review for updating and revision for the next contracting cycle.

NH Bureau of Behavioral Health Service Array (document)

Maintenance: Specialized outpatient services exclusively for BBH eligible persons including: Individual, group, and family psychotherapy; Specialized treatment services to eligible persons with mental illness and a concomitant alcohol and/or substance use disorder, including assessment of alcohol/substance use disorders as part of the clinical evaluation process and provision of treatment for both the substance use disorder and the mental illness, as necessary; and Medication services, including psychiatric and nursing assessment, medication prescription and monitoring, oral and intravenous administration, and education.

Children and Adolescents: Specialized services to children who are eligible for services pursuant to He-M 401. Services provided to eligible children shall be community-based and provided in natural settings. Services provided to children shall include the following: Family support and education, which may include designation of a family liaison; Psychiatric diagnostic and medication services; Case management, including appropriate interagency involvement; Individual, family, and group therapy; Intake and assessment; Crisis intervention; Outreach support to children and their families, both in their homes and in community settings; Respite care; Sexual offender assessments and treatment; and Treatment of attachment disorder. Intake, emergency, case management, and other services when performed by children's services staff, are allocated to the children's program.

Elderly Services: Specialized services to elderly persons residing in community settings who are eligible for services pursuant to He-M 401. Services provided to elderly persons shall be community-based and provided in natural settings. Services provided to elderly persons residing in community settings shall include: Intake and assessment; Psychiatric diagnosis and treatment; Case management; Consultation and education to families, community agencies, and the general public; Outreach supports to elders and their families, both in their homes and in community settings; and PASARR evaluations, coordinated with nursing homes, hospitals, and BBH, as needed. Intake, emergency, case management, and other services, when performed by elders' services staff, are allocated to the elderly services program.

Elders' services programs include specialized services for age related difficulties. For persons aged 60 or more who are eligible for and served in CSP programs such as case management and maintenance, services shall be allocated to those CSP programs.

Intake: Intake services to determine BBH eligibility when organized as a discrete program and not performed within other service programs.

Emergency Services/Assessment: Face-to-face interventions for the purpose of: Reducing a recipient's acute psychiatric symptoms; Reducing the likelihood of the recipient harming self or

others; and/or assisting the recipient to return to his or her pre-crisis level of functioning. Conducted with the therapist in direct, personal, involvement with the recipient to the exclusion of other recipients and duties. Emergency services shall be available 24 hours a day, 7 days per week and be accessible to individuals anywhere in the region served by the CMHP.

As follow-up to the initial emergency response, a client shall be eligible to receive a maximum of five (5) emergency service sessions, consisting of not more than six (6) 15 minute units per session, for the purpose of stabilization of the emergency situation prior to intake or referral to another service or agency. Emergency services shall be billed in 15-minute units, and shall be limited to six (6) units per recipient per day to a maximum of six (6) sessions per period of acute psychiatric crisis. Emergency services shall be provided by staff of discrete emergency services programs or other staff serving as part of a formalized emergency services rotation.

In addition to face-to-face contacts, allowable and reportable activities may include telephone contacts with a client (to stabilize the client and/or avert a worsening of the crisis) and consultation to other caregivers (as an adjunct to the face-to-face contact). All people experiencing a psychiatric emergency are eligible for BBH or Behavioral Health support for this service. Initial assessments (intakes) if performed by emergency staff, or if intake and emergency services constitute a single unified program, can be included here. Crisis intervention provided outside of the discrete Emergency Services program should be allocated to that other program and shall not be billed to Medicaid as Emergency Services. Only a discrete Emergency Services program can bill Medicaid for Emergency Services.

Brief/DRF: Brief hospitalization services, including agreements with local hospitals to provide inpatient treatment alternatives to New Hampshire hospital; and "Designated receiving facility" (DRF) means a hospital-based psychiatric unit designated by the director to provide care, custody, and treatment to persons involuntarily admitted to the state mental health services system. Only clients who meet BBH eligibility criteria are eligible for Bureau of Behavioral Health support for these services. Indigent care subsidies, professional services specific to the hospital stay, or other direct activities in maintaining hospital access are considered brief/DRF hospital services.

Intensive Partial Hospitalization: Partial hospitalization services shall be provided by a community mental health program or community mental health provider or as out-of-facility activities pursuant to He-M 426.10(d)(1). Only clients certified to receive long-term care services pursuant to He-M 426.16(b)(1) shall be eligible for these services.

Programs shall operate a minimum of six (6) hours per day on weekdays and four (4) hours per day on holidays and weekends for each day for which services are billed. Billing for partial hospitalization services shall be in half day or full day units, as follows: One (1) half-day of partial hospitalization shall be attendance at staff directed programs for at least two (2) and less than three (3) hours; and a full-day of partial hospitalization shall be attendance at staff directed programs for three (3) or more hours.

Intensive partial hospitalization services shall be provided as follows: Placement into intensive partial hospitalization shall be made only with a written order from a psychiatrist, and shall be

based on symptoms affecting the recipient's ability to function adequately in a community setting; Intensive partial hospitalization shall be offered no fewer than five (5) days per week and shall be designed to provide short-term, structured, and active treatments which are problem-solving in nature and which are directed toward full or partial recovery from the prevailing crisis and the return of the recipient to a pre-crisis level of functioning.

The provision of intensive partial hospitalization services shall be based on identified recipient needs as documented in the recipient's ISP. Intensive partial hospitalization services shall include: Individual and/or group psychotherapy; Psychological evaluations and testing; Medication monitoring, evaluation, administration and education; Clinical assessment to assist in individual service planning; Family/significant other psychotherapy; and Psychologically supportive individual and/or group activities; The daily services and activities of an intensive partial hospitalization program shall consist of: A minimum of two (2) hours per day of any combination of activities contained in He-M 426.10(f)(5)a.-e. above; and the remainder of the day may consist of activities contained in He-M 426.10(f)(5)f. above; Participation in this program shall not exceed twenty (20) treatment days per acute episode without a written order from a psychiatrist and a documented service plan review; and there shall be no reimbursement from Medicaid for any treatment exceeding thirty (30) days per episode, or ninety (90) days per state fiscal year.

Restorative Partial Hospitalization (by location): Services shall encourage the development of those skills necessary for transfer to a variety of community living environments, including employment settings, and shall, as much as possible, reduce a recipient's dependency on state and/or federally funded programs while enabling the recipient to become a productive member of society, earn a wage, and live as independently as possible.

Placement and participation in restorative partial hospitalization shall be based on the needs of the recipient as documented in the ISP and functional deficits identified in the eligibility determination process pursuant to He-M 401; Restorative treatment shall: Promote emotional, behavioral or psychological change; Minimize the effects of mental disorders; Promote health maintenance through clinical activities which foster the reduction of psychological stress; Promote independent living; Help maintain the client in a community setting; Teach skills necessary for a client to function in the environment in which he or she lives and/or works; and Utilize accepted principles of psychosocial rehabilitation.

Restorative partial hospitalization services shall consist of the following components: A comprehensive identification of the recipient's skills, strengths, and deficits in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function, as such environment is consistent with the goals listed in the client's SIP; Active recipient involvement which requires that assessment and intervention procedures be explained to and understood by the recipient; Teaching of skills necessary for the recipient to succeed in his/her chosen environments; A crisis management plan which shall serve to avert crises or shall mobilize resources rapidly to respond to crises and may be implemented by intensive partial hospitalization services staff, emergency services staff or other appropriate staff within the CMHP; and Case management to assure linkage with all necessary services and

people involved in the recipient's care, coordinated service planning, and monitoring of progress toward goals.

Restorative partial hospitalization services shall include the following services: Individual and/or group counseling and psychotherapy; Medication monitoring, evaluation, administration and education; Family/significant other services, counseling and psychotherapy; Teaching daily living skills, community living skills and self-care skills; Nutritional services; Basic education; Leisure/recreational services; Psychological evaluations and testing; and Psychologically supportive individual and/or group activities; Recreational activities such as bowling, swimming and field trips shall be billable only when they are adjunct to, but not the only component of, the restorative partial hospitalization service; and Medicaid reimbursement for restorative partial hospitalization services shall not be made for a recipient for any day in which the recipient receives fewer than two (2) hours of service, exclusive of recreational activities, unless in a given week the average per day participation in non-recreational activities exceed two (2) hours per day of service to the recipient.

Vocational Services (by location): Employment services, including: Vocational assessment and service planning; Competitive employment and supported work placements; Employment counseling and supervision; Peer supports, such as job clubs and client support groups; Job development; and Employer consultation and education.

- **Supported Employment:** NH has implemented the EBP Supported Employment (SE) statewide, which is conducted by the CMHCs in collaboration with Vocational Rehabilitation (VR). BBH established an MOU with VR to establish parameters and expectations of the mutual interaction. The team-based approach is goal-directed to assist individuals who would like to work in secure competitive employment at living wages. Supported Employment has largely replaced partial hospitalization in NH. Vocational Rehabilitation funds enhance state general funds supporting employment services.

- Individual Career Accounts and Individual Development Accounts are geared towards reducing/eliminating poverty for working persons earning very low, inadequate the so-called "working poor". They offer educational, vocational, and home ownership programs. NH's Medicaid for Employed Adults with Disabilities Program (MEAD) allows adults with disabilities, including mental illness, to earn a higher salary and save money without losing their Medicaid eligibility, as does the SSI's PASS program (Plan to Achieve Self Support).

Case Management: Case management services assist clients eligible under the state plan in gaining access to needed medical, social, educational, and other services, on a one to one basis only; Activities include:

(1) Assessment and periodic reassessment of an eligible individual to determine service needs, including the following activities:

a. Taking client history;
b. Identifying the needs of the individual and completing related documentation; and

c. Gathering information from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the eligible individual;

(2) Development and periodic revision of a specific and comprehensive care plan based on the information collected through an assessment or reassessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. An individual may decline to receive services in the care plan;

(3) Referral and related activities to help an individual obtain needed services, such as scheduling appointments, but not including transportation, escort, and childcare services; and

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring is required on a quarterly basis.

No direct care clinical services shall be reported as case management.

Social Club/Peer Supports: Peer supports organized by agencies or consumers themselves includes agency sponsored consumer run businesses as well as drop in centers and warm lines.

Non-specialized Outpatient: Outpatient programs which provide any or all of the following services without specialized program models: intake, outpatient, children, elders, maintenance (CSP outpatient), etc.

Multi-Service Team: Services are organized and delivered by a multi-service team that provides an array of services and supports to a discrete caseload. This service array may include case management, therapy, supportive housing, vocational services, etc. This includes low caseload Continuous Treatment Teams that provide treatment to individuals who have a serious mental illness and also have a history of substance abuse. Through aggressive outreach services, teams help to interrupt the cycle of relapsing mental illness and periodic or continued substance abuse. The teams take clinical responsibility for this population, regardless of the setting where the client is found. A Continuous Treatment Team means a team of licensed practitioners of the healing arts and other mental health clinicians whose caseload is twelve (12) or fewer clients per direct service staff and who provide intensive treatment through an array of services to clients who have mental illness and may have a history of substance abuse. Services provided by such a team qualify for the Continuous Treatment Team exemption to all inclusive IPH and RPH Medicaid reimbursement.

Respite Crisis: Respite housing provides temporary in or out of home relief for the person(s) with whom the individual lives. Respite housing may also be appropriate for providing temporary emergency shelter to people without shelter, or for people who are temporarily in need of short term respite because their social environment may not be supportive or may not be capable of supporting the individual. Include here all crisis/respite beds which are no more than a short-term bed in a community residence.

Respite for children should be in financial reports under children's services. Statistics on the use of respite by children will be reported under "respite" in the separate children's statistical report.

Acute Psychiatric Residential Treatment Program: Acute psychiatric residential treatment program (APRTP) means a program that: Is implemented in a non-hospital-based designated receiving facility; Provides 24-hour, voluntary and involuntary psychiatric treatment and care;
Is designated and structured to provide intensive, short-term mental health services to persons who have acute psychiatric disorders or are in an acute phase of their mental illness and who do not require concomitant hospital-based medical care; and is administered by a community mental health program as a component of an integrated and coordinated system of mental health services.

Community Residence (by location): Community residence means either an agency residence or family residence exclusive of any independent living arrangement: Which provides a residential program for at least one person 18 years of age or older with a developmental disability or a mental illness; which provides supervision for an individual present in the home.
Which meets either of the following criteria: Receives residential placement of persons from services and programs operated, funded or regulated by BBH; or Receives funds or allowances either directly or indirectly from the New Hampshire department of Health and Human Services, a community mental health program or an area agency.

Supported Living: Agency operated facility based housing with supports less than those required for community residence licensure, or flexible supports in natural environments, usually MIMS, in clients' homes or other community settings.

Independent Housing: Apartments located in an agency operated, subcontracted, or agency subsidized housing where no supervision other than routine case management services exists in the residence.

Community Education and Training: A CMHP shall conduct community education activities, including the provision of education and consultation to members of the community at large, with the goal of increasing the acceptance of persons with mental illness. Activities shall include working with the media, public speaking and information dissemination.

The purpose of staff development and training is to strengthen staff capability to provide services in the Bureau of Behavioral Health and Developmental Services funded programs. These activities shall address the deficit between perceived and desired staff competencies in (1) their ability to respond to client needs; and (2) their ability to function efficiently within the organization.

Illness Management and Recovery (IMR) is an EBP that focuses on recovery strategies, education about schizophrenia, stress vulnerability and treatment strategies. IMR includes building a system of social supports, effective medication management, reducing relapses and receiving appropriate treatment in the mental health system.

Other Mental Health: This is to be used only with BBH permission for programs that do not fit any other category.

----END of Document----

The services described below are applicable to all citizens. Many are associated with the prevention of hospitalization.

Medical and Dental Services: Community Health Centers (CHCs) provide comprehensive primary and preventive medical and dental health care delivery. CHCs are owned and operated by the community, and serve everyone regardless of their ability to pay. In NH, there are 13 CHCs serving over 90,000 patients. CHCs provide immunizations, prenatal care, maternal and child health services, cancer and other preventive health screenings, preventive dental care, chronic disease management and free and reduced cost prescription drug services to vulnerable people and their communities. Medicaid does not have a dental benefit other than those surgical procedures covered under the medical benefit and the many dentists provide services on a cash pay basis only. CMHCs are provided some free dental care in many communities.

Ryan White funding supports medical services to individuals who are sero-positive.
The Ryan White CARE Act Dental program in NH provides funding to both a community-based dental program, to increase access to oral health care services for HIV-positive individuals while providing education and clinical training for dental care providers, and a program which reimburses dental schools, postdoctoral dental education programs, and dental hygiene programs for oral health care of individuals living with HIV.

Educational Services: Services and programs to assist adults with SMI in improving or attaining their educational goals are generally limited to the services provided by Vocational Rehabilitation and the New Hampshire educational opportunities that are available to all. Individual agencies may offer specialized programs. The NH Department of Education funds the school system to provide services under the Individuals with Disabilities Education Act (IDEA) to children and youth with IEPs, up to age 21.

Mental Health Courts: MH Courts continue to operate at the District Court level in Nashua, Keene and Rochester and a new MH Court opened at the Portsmouth District Court in August. Stakeholder groups continue to meet in Concord, Manchester and Laconia to discuss formation of such courts in their communities. BBH is highly involved in the community-based efforts to expand the establishment of mental health courts and the adequacy of treatment programs to which the courts may refer. Funding for such courts remains a challenge.

In conjunction with the planning and implementation of the mental health courts, BBH and CMHC staff have educated judiciary, correctional and law enforcement in mental health and mental health issues. Staff have participated in day-one of a two day District Court Judges' conference, presenting on mental health. A BBH staffer is on a planning committee for a conference for judiciary, legislators, law enforcement, and corrections, to explore mental health issues and the interaction of the courts, jail and mental health.

Joint Family Support Assistance Program for the NH National Guard: Article courtesy of Jo Moncher, Bureau Chief, Community Based Military Programs, Department of Health and Human Services. This article is inserted to highlight this project in detail.

NH's Department of Health and Human Services is a primary partner, with the NH National Guard, in the design and implementation of a pilot mental health service model, Joint Family Support Assistance Program (JFSAP), to be delivered to members of NH's National Guard who are being deployed to the Middle East or are returning from service there. Over 2,650 service members are serving in the NH Army National Guard and Air National Guard; hundreds have deployed to war zones and at least 1,000 more are expected to deploy over the next two years. Troops deploy to the war arena for up to 18 months, and an increasing number deploy more than once. These military personnel and their families do not reside on base, do not have access to military commissaries that provide goods at reduced rates, and have far less access to chaplains and family support groups. They are not part of a tight-knit community of families with similar circumstances living in close proximity.

Instead, when the service member deploys, the family remains behind in their hometown. Suddenly these families are single-parent households. Income drops drastically – military pay often does not approximate civilian pay and many service members work in skilled trades and/or self-employment, where there is no paid time-off. The spouse at home may need to reduce work hours to care for children. Many military families are young, financially inexperienced, and unprepared for emergency expenses. Children can experience serious adjustment issues when a parent is away fighting a war that is constantly referenced in the media and at school. Children may act out, become isolated, and experience other behavioral difficulties. Families feel alone because they are separated from a loved one and living in the civilian community where fewer people can relate to their challenges. Family members also deal with fear and anxiety; many turn inward, cutting off from others and engaging in compulsive news-watching.

Many returning service members endure traumas that result in Post Traumatic Stress Disorder; the hyper-vigilance and detachment get in the way of reconnecting with children and spouse, returning to work, getting along with others, achieving good sleep, etc, and can lead to dangerous or obsessive behaviors, anger management problems, and substance abuse. Some veterans sustain closed brain injuries that are difficult to detect and impede cognition and emotional functioning. Returning to productive civilian employment is a challenge and physical or emotional injuries can impact the ability to perform the pre-deployment job. Self-employed service members often find they have lost their customer-base while away. As a result of these circumstances, mental illness, substance abuse, domestic problems, unemployment, homelessness, legal struggles, and other challenges are more prevalent in military populations.

The New Hampshire Joint Family Support Assistance Program (JFSAP) model was designed to provide holistic support to military personnel, returning veterans, and their families, through a pro-active framework that brings civilian resources into the military and encourages military families to access civilian services. The interventions begin well in advance of military deployment, and initially take place at the military site during drill weekends, thus making participation part of the regular military experience, which helps reduce stigma. Service members and their families are assigned a Care Coordinator who is the family's "one-stop" point

person for support in assessing, planning, and accessing services. The Care Coordinators are highly skilled clinicians who help determine risk and resiliency and work with the service member and his/her family to create a plan for anticipating and reducing future problems through comprehensive support – including clinical counseling, various social services, and even emergency financial assistance when needed, accessed through a philanthropic flex fund. The Care Coordinators then continue to work with the family once the service member deploys and after the service member returns to the challenges of reunion and reintegration.

The JFSAP team has made great strides – nearly 500 New Hampshire service members/veterans/ families are now in the program and the team is confident that the formal pilot program evaluation will show that the safety net established through the pro-active, integrated model and care coordinator relationship will make a big difference in mitigating future problems. But there are extremely challenging implementation issues that can only be addressed with high-level policy change and implementation. Critical to the emerging framework is the establishment of local "front doors" through which service members, returning veterans, and their families can access community-based services. The services are largely there already – that is, Family Resource Centers (FRCs), Community Mental Health Centers (CMHCs), Adults with Disability Resource Centers (ADRCs; called "ServiceLink" in NH) and other community based service providers such as Easter Seals NH (which has a statewide presence in New Hampshire) offer a host of supports that these families need, and they can be and are being delivered effectively due to appropriate personnel training and civilian-military partnering.

Training is a critical need. Mental health professionals who can treat combat related PTSD and provide services statewide are crucial to meeting the reintegration needs of returning troops. But even with a well-trained civilian workforce, there are challenges. Many of these stem from the fact that the points of access through which military personnel/families could receive services in the civilian social service framework are not fully in place. Easter Seals NH continues to provide most of the care coordination and many of the actual services even though the FRCs and CMHCs are eager to participate. The pilot model implementation process is currently challenged with a critical roadblock in achieving full-scale, sustainable, community-based integration.

New Hampshire

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Estimate of Prevalence: Adult System

These are 2007 statistics, from the New Hampshire URS tables, the Bristol Observatory (NH data sets), and the US Census for NH. The Bristol data was analyzed using the Probabilistic Population Estimation statistical procedure of Steven Banks and John Pandiani, for NH's new Population Overlap Estimation project. The POE data corrects the overlap in the current URS table data, due to NH not having an unduplicated counting system. The POE unduplicated count, measured over several years, indicates a 5.2% rate of duplication.

Consumers of all ages receiving publicly funded mental health services in community mental health settings numbered 46,906 (FY07-URS duplicated count). Approximately 3.5% of the NH adult population is served in the public mental health system, per the URS data. This is over 35,000 adults served. Mental illness prevalence for the state is estimated by SAMHSA to be approximately 5.4% of the adult population. This is about 54,500 people. Important note: The federal definitions for serious mental illness are less restrictive than the State definitions for State-eligible SMI, and therefore the State definitions are applicable to a smaller segment of the population served.

State Population	**1,309,940**
Number of adults living in state (US Census)	1,009,036
Number of adults with serious mental illness living in state (federal est.)	54,487
Number of State-eligible adults with serious mental illness served (URS)	8,801
State prevalence for adult serious mental illness (federal est.)	5.4%
Percent of adults with SMI served in public mental health system (state def.)	16%
Percent of adults with SMI served in private system or not served (fed. def.)	84%
Number of adult recipients of community mental health services (URS)	35,174
Percent of adult population served in the public MH system	3.5%
Percent of State-eligible adults of all adults served in the CMHC system URS)	25%

The State-eligible population is the priority population to be served with BBH funding to the Community Mental Health Centers, and BBH conducts annual eligibility audits at each of the CMHCs to confirm that the eligible population is receiving the required services. Per URS Table 2a, 2007, the CMHCs served 26,373 adults who were not State-eligible adults with SMI, or 75% of the 10 CMHCs adult service enrollment per the URS data.

It is of note that as the data reporting, collection, and analysis improves we are beginning to identify a growing population of individuals who do not meet the criteria for State-eligible services, may not have private insurance or Medicaid, and have low incomes. The community mental health system is the resource most utilized by this segment of the population, and it is being stretched to the limits, financially.

Per NH Chapter He-M 400 Community Mental Health-Part He-M 401 Eligibility Determination and Individual Service Planning http://www.gencourt.state.nh.us/rules/he-m400.html

"Mental illness" means the following psychiatric disorders classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR):

(1) Schizophrenia and other psychotic disorders; (2) Mood disorders; (3) Borderline personality disorder; (4) Post traumatic stress disorder; (5) Obsessive compulsive disorder; (6) Eating disorders; (7) Dementia, where the psychiatric symptoms cause the functional impairments and one or more of the following co-morbid symptoms exist: a. Anxiety; b. Depression; c. Delusions; d. Hallucinations; or e. Paranoia; or (8) Panic disorder.

In addition, Peer Support Agencies provide an array of services and supports to persons with serious mental illness. Many of the members receiving peer support services no longer receive services from the CMHCs, or receive intermittent, limited services from the CMHCs. Peer support members are not registered as service recipients in the client database, but are reported as PSA members. The actual number served by the PSAs is currently unknown because not all participants are members, but the count of members for FY07 is 2,900.

New Hampshire

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Quantitative Targets: Adult System

BBH sets quantitative targets to be achieved in the implementation of the system of care, described under Criterion 1 (Adult Plan and Child Plan), based on the data collected from the CMHCs, the BBH information system, BBH reports, and other credible data sources, and as reported in the required URS tables, to the extent of the capacity to do so.

BBH's data information system is called Phoenix, and is in the final stage of being the fully functional replacement of a previous system. The transition from the previous system to Phoenix has made some of the data appear differently from one year to the next. FY08 data is not yet available due to technical problems. Notes regarding data issues appear in Part C, Section III. Goals, Targets and Action Plans, under Special Issues.

New Hampshire

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

Outreach to Homeless: Adult System

The Bureau of Homeless and Housing Services manages an array of housing programs, such as Shelter Care Plus and Supported Housing, among others, which also assist individuals with mental illness. Per the NH Housing and Homeless 2007 Annual Report, of 5,609 persons sheltered in FY07, about 20% (n=1,113) self-reported having a mental illness and almost 10% (n=545) reported having a mental illness and a substance use disorder. Report may be accessed at http://www.dhhs.state.nh.us/DHHS/OHHTS/LIBRARY/Program+Report-Plan/ann-rpts.htm

The statistics and information below have been excerpted from the report. In NH, PATH funds are contracted to community mental health and community action programs to provide services to those experiencing homelessness and serious mental illness (SMI) or SMI and a co-occurring substance use disorder. Services include outreach, screening and diagnostic treatment, staff training and case management. PATH case management services involve providing assistance in obtaining and coordinating services for the chronic homeless, assistance in obtaining income support services, housing assistance, food stamps, and supplementary security income benefits.

PATH workers assess for immediacy of needs, and continue to work with the individual to enhance treatment and/or housing readiness. PATH workers' continued efforts help to connect chronically homeless with vital supports, including emergency and/or permanent housing, primary health care, financial assistance, and mental health treatment.

In SFY '07, PATH service workers provided outreach services to 1,213 individuals. Of these, 1,106, or 91% of those receiving outreach services were enrolled as PATH clients. Six community mental health agencies and one community action agency received PATH grant contracts to continue to provide PATH services.

As noted in the Adult Plan, Part C, Section II, Significant Achievements, NH was selected to receive technical assistance to implement SSI/SSDI Outreach, Access and Recovery (SOAR), designed to increase access to the SSA disability programs for homeless persons with disabilities, including serious mental illnesses and/or co-occurring disorders. SOAR (is)...increasing successful enrollments for persons who are homeless - on the first application and without lengthy delays or appeals. From an initial level of 10-15% approval rates, the average is now over 60%, and the number of days to an initial SSA decision has been cut from 120 to 87 or less. The result of these targeted efforts, which reach applicants who have been homeless for an average of 33 months, reduces agency backlogs and achieves benefits for individuals, including health care and support in permanent housing." (Source: United States Interagency Council on Homelessness e-Newsletter 8/9/07)

The initiative is sponsored by the US Department of Housing and Urban Development and the US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration. In October of 2007, the Bureau of Homeless and Housing Services hosted a State Planning Forum which "...provided the information, tools and time to plan state and community-specific approaches to increasing access to disability benefits for those persons who are chronically homeless, particularly for those who have serious mental illness and/or co-occurring disorders." per the BHHS 07 Annual Report.

New Hampshire

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

Rural Area Services: Adult System

Seventy-seven percent of NH municipalities are non-urban or rural. New Hampshire citizens in rural communities face geographic barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals. Access problems facing many rural residents are generally compounded for those with mental illness. The most rural, Coos County, (pronounced Co-Ahss), has the state's largest landmass and the smallest population, and experiences the chronic health care access, economic and employment problems common to heavily rural areas. All community supports in this area are stretched thin at this time.

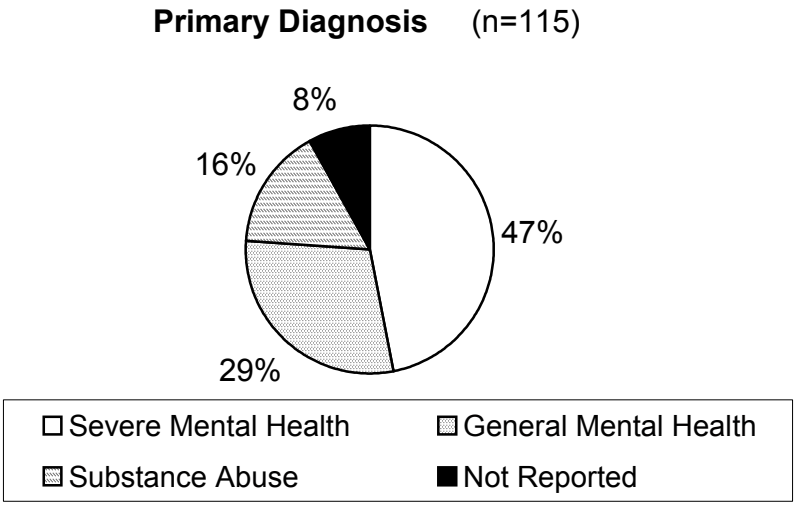
This area in particular is highly underserved, and has/recently had federal designations of Health Professional Shortage Area (HPSA), Dental Health Professional Shortage Area (DHPSA), and Mental Health Professional Shortage Area (MHPSA). The area lost ten inpatient psychiatric beds as a result of the unexpected closing of the Androscoggin Valley Hospital, the only Designated Receiving Facility (DRF) in the area. The loss presented additional challenges to the already difficult task of locating or creating additional community-based alternatives to inpatient care at NHH and increases admissions to the State hospital.

Region I's Northern Human Services utilizes a multi-service care model integrating mental health, developmental services and substance use/abuse services in a network of CMHC satellites. This has increased the efficiency of the provision of services to those consumers who are dually eligible for mental health and developmental services. Telehealth and training via teleconferencing and video conferencing is utilized heavily for rural areas, and the PSAs in the rural areas also provide a comprehensive array of peer support services. The CMHCs in the rural areas do as much as possible, with the limited resources available, to prevent involuntary admissions to NHH, but for now this remains an ongoing challenge.

The Region I CMHC must serve seven hospitals in three counties. If the CMHC has only one psychiatrist or crisis worker on call, there may be multiple delays if several community hospitals have people presenting with psychiatric emergencies. "Mental Health Needs in Rural Hospital Emergency Departments" is a report on data collected from 10 emergency departments (ED) in rural community hospitals. It was found that there were 115 patients who presented in the ED with a primary diagnosis of mental health or substance abuse and required an in-patient admission for the problem(s). This data was collected to better understand the need for in-patient behavioral health treatment services for people from rural communities where smaller community hospitals do not have the needed...services.

Almost half (47%) of the patients reported a severe mental health problem (e.g., bipolar, schizophrenia, etc.). General mental health problems (e.g. anxiety, panic disorder, etc.) accounted for 29% of the patients. Sixteen percent had substance abuse as the primary diagnosis. There was no data reported for 8% of the patients. Most patients were age 18 years or older (76%) but about one in five patients (23%) was a child or adolescent. Most patients (81%) had health insurance. Medicaid coverage accounted for almost a third (30%) of all the patients. Fifteen percent of patients were self pay/no insurance and data was not reported for 4% of the patients. ...(Six percent) spent more than 12 hours in the ED. Local police or the county sheriff transported 42% of the patients to another hospital where they could be treated and 23%

were transported by ambulance or medical transport. Others traveled in a private vehicle. Data was collected by each hospital for the period January 1 to March 31, 2008. The number of patients presenting at each ED ranged from 26 to 4.



Community hospitals located in Colebrook, Woodsville, Berlin, North Conway, Littleton, Lancaster, New London, Claremont, Wolfeboro and Peterborough participated. (Source: Foundation for Healthy Communities Draft Report July 2008; abridged) These are New Hampshire Community Mental Health Regions I and II.

New Hampshire

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

Older Adults: Adult System

The Bureau of Behavioral Health is involved in many older adult interagency activities, such as NH's Coalition on Substance Abuse/Mental Health and Aging, the development of Elder Wrap, the Cross Bureau Committee, interagency older adult trainings, and the continued funding and coordination of the multi-agency supported Referral, Education, Assistance and Prevention (REAP) programs. BBH works closely with the Bureau of Elderly and Adult Services, the Bureau of Homeless and Housing, the Office of Alcohol, Tobacco, and Other Drug Policy, the Dartmouth Community and Family Medicine-Center for Aging and NASMHPD Older Persons Division. The Bureau has a designated fulltime staff person who works specifically on behalf of older adults with mental illness. Recently, the newly appointed Commissioner of Health and Human Services Nick Toumpas attended a MH and Aging Consumer Advisory Council meeting and said that "Mental Health" as well as "Aging" were among his top priorities.

Each of the CMHCs has a Director of Older Adult MH Services. Most have designated older adult case managers and six of the ten have a Geropsychiatrist. These older adult programs are managed locally and offer outreach and supports in natural environments (home, senior centers, medical office), including consultation and services to many nursing homes. The continuum of services varies depending on the needs and resources of each region and includes Intake and Assessment, Medication Management, Psychotherapy, Pre Admission Screening and Annual Resident Review (PASARR), Functional Support Services, Emergency Services, Case Management, REAP. Three sites have an older adult residential Home and Partial Hospital. Peer Support services are available to older adults through the Peer Support Agencies. The Directors of Older Adults meet monthly with BBH to review policy, programs, billing, budgets, rules, regulations, and best practices.

Specialized mental health initiatives for older adults currently include:

♦ The continued implementation of the evidence-based practices Supported Employment and Illness Management and Recovery now includes adults 60 and over. This age group was not originally incorporated. There was a training on IMR held this year which included older adult program staff. Other EBPs include Cognitive Behavioral Therapy and Older Adult-Substance Abuse Brief Interventions.

♦ The REAP project is a multi-agency early intervention program for older adults that reduces hospitalization for mental illness and substance use and medical hospitalizations due to injury, falls, and accidents associated with medication or substance use. This approach leads to identifying older adults who otherwise would not have sought services in the traditional manner, due to stigma and lack of motivation. BBH provides funding along with three other entities to the Seacoast MH Center, which administers the project statewide through the CMHCs. REAP offers free and confidential services to older adults in New Hampshire communities statewide.

There are 38 trained REAP Counselors. In FY08, over 3,300 older adults were served. Services include assessment, referral, brief counseling, interventions, technical assistance to caregivers/others and educational wellness trainings in older adults' natural settings, including in their homes. In FY09, training for new and existing staff will be provided and outreach will be

extended to increase caregiver participation. The REAP project is currently working with the Northeast Center for the Application of Prevention Technologies (NECAPT) on the "Service to Science Initiative". It is anticipated that this project will be awarded a grant that will support the REAP program to become recognized as an EBP or Promising Practice.

♦ The "Outcome Based Treatment Plan" for older adults with a serious mental illness is under review and being updated: This multipurpose tool was developed in the late nineties by Dartmouth Psychiatric Research Center in conjunction BBH and the 10 CMHC's. It has been instrumental in providing specialized clinical guidance for clinicians working with older adults. Assessments will be updated and the process simplified.

♦ The Mental Health and Aging Consumer Advisory Council, established in 1998, has approximately 25 active members, plus an additional 30 former members who generally cannot attend meetings but wish to remain informed and provide input. Seventy-nine percent of the active members are older adult MH consumers/family members, and 21% are older adult advocates from other agencies. Members serve on State committees, NAMI NH, agency Boards of Directors, the Commission on Mental Health, and others. The MH & Aging Council interacts with organizations involved with older adult services, to work on the problems and needs facing that age group. The Bureau is supporting accommodations for the Mental Health and Aging Consumer Advisory Council through the MH block grant funds. For FY09 the MH & Aging Council will participate in the State Plan Advisory Project, and provide the Bureau with recommendations for the consideration prior to the next biennial budget and planning cycle.

♦ New Hampshire Hospital provides psychiatric and neurological care in a unit that specializes in older adults, delivered in the main hospital, and Glencliff Home is a State-run nursing home (Intermediate Care Facility) serving older adults with an SMI and/or developmental disability, in a home-like environment.

♦ Elder Wrap: There are now 14 communities who have a "wraparound" process for older adults. The process helps communities maximize local resources to improve access to older adult with multiple needs, including mental health/substance abuse-related needs. Elder Wraparound teams provide person-directed care to older adults with multiple agency involvement who are at risk of "falling through the cracks", such as homeless individuals or persons who are socially isolated. Public and private partners are committed to working together to address the needs of the older adult who would benefit from a coordinated all-inclusive plan. Consumers/family members and advocates are invited to participate and there is no cost to the consumer. Training and best practice initiatives are being planned for 2009.

♦ Through the Family Mutual Support Grant that was awarded to NAMI NH, older adults and their families have access to support, education and leadership development. An 8 week educational series called "Side by Side" will be offered in the fall of 2009 to caregivers and older adults in several locations statewide.

♦ The Cross Bureau Committee is a state level interagency collaborative involving multiple organizations that work with one another to foster relationships and develop policy. Case specifics which are unresolved at the Elder Wrap community level are raised and addressed by

this Committee. Representatives from the Bureau's of Elderly and Adult Services, Behavioral Health, Developmental Services, Homeless and Housing make up the team, which is directed by the Deputy Director of the Division of Community Based Care Services.

♦ Suicide Prevention for older adults is now addressed in the State Suicide Prevention Plan. Additional representatives/advocates for older adults are working with the Suicide Prevention Planning Council, resulting in specific workshops offered in communities.

♦ The Coalition on Substance Abuse MH and Aging has been instrumental in the re-development and refinement of the REAP program, including supporting and managing the current Service to Science effort. Recently a "Healthy Aging Medication and Alcohol Tips" sheet was developed by the Coalition in collaboration with the DHHS's Alcohol, Tobacco and Other Drug Clearing House and other older adult "Tip Sheets" are under consideration.

♦ The Nursing Facility Transition Project, initially established under a CMS grant, is sustained by BBH through a contract with Riverbend CMHC. The project continues to divert and transition older adults from NHH and nursing homes. In FY08 technical assistance was provided to NH's Money Follows the Person project, now know as Community Passport, which includes those with an SMI who are able and want to leave a nursing home to live in the community.

♦ Supportive Community Engagement (SCE) for Older Adults with Serious Mental Illness is the name of a BBH-Aging Services Research Group collaborative proposal submitted to SAMHSA in 2008. The project is designed to assist older adults with mental illness to take on meaningful roles and responsibilities within their community. Older adults with SMI between age 50 and 65 are 2 ½ times more likely to enter a nursing home than persons of the same age without a mental illness. While EBP implementation among people with SMI is relatively widespread in New Hampshire, older adults have not been included in large numbers. Thus, the potential for EBPs to reduce premature institutionalization is not currently being realized. The SCE project would work toward reversing these trends in older adults with a two-pronged approach to enhance the cultural competence and make age-related modifications to an established EBP, Supported Employment. The Notice of Funding Awards has not been made to date.

♦ The Dartmouth Community and Family Medicine Center for Aging is led by Steve Bartels, MD, a national leader in the field of geriatric substance abuse and mental health treatment. The research group is focusing on developing and evaluating clinical practices and interventions to address the needs of older adults with emotional problems. This group works with the MH and Aging Consumer Advisory Council.

♦ To show that simple lifestyle changes (increased exercise, better nutrition, and smoking cessation) can improve the quality of life for individuals with mental illness, Riverbend Community Mental Health in Concord (Region IV) and researchers at Dartmouth are conducting a study of Riverbend's In SHAPE (Self Health Action Plan for Empowerment) program, which will include studying the benefits to adults over 55 with mental illness. In FY09 a new study is funding explorations in Manchester, Concord, and Keene of how to provide a less expensive, less intensive program for people who either have already experienced the In SHAPE program (Keene or Concord) or where funding for In SHAPE does not exist (Manchester).

New Hampshire

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Resources for Providers: Adult System

BBH staffing was significantly impacted by the Governor's mandate to reduce personnel and the subsequent hiring freeze, which although technically lifted, is effectively sustained by repeated budget cuts that impact the ability to fill vacancies and retain vacant positions. Of note, the State's position for the coordinator of the Children and Adolescent's Mental Health Services is vacant and a requested waiver to fill it has not yet been granted. This has a tremendous impact on the degree of ongoing immediate and routine interactions normally available to providers from this crucial State resource. This position interfaces with multiple systems, both children's and adult, and is a key source of expertise to move the integration of children's services forward.

The Bureau Administrator, in consultation with the Director of the Division of Community Based Care Services continues to prioritize BBH activities and modify staff assignments to meet the needs of the Bureau. The BBH Administrator works closely with the CMHC Executive Directors and the Mental Health Planning Commission to address issues of staff recruitment and retention and human resource issues impacting the Department of Health and Human Services.

With the development of EBPs across all regions, BBH recognizes the importance of training individuals in these practices in order maintain the workforce. The Bureau has developed an expansive training curriculum, which is offered to all CMHCs free of charge, to assist individual centers with workforce development. To the extent possible, billing rates are adjusted to decrease the payment gap between Medicaid and other insurance, and the CMHCs do what they can to offer salaries that are more competitive with the private sector, although there is little evidence of this being sufficient to prevent staff from leaving the public mental health sector for better pay.

Trainings for providers in support of staff development are ongoing. Some of the major offerings provided by BBH include, but are not limited to:

The Technical Assistance Grant for Person Centered Treatment provided technical assistance and training in FY08 for the staffs of the Community Mental Health Centers

Statewide training for Supported Employment and Illness Management and Recovery has been held and is ongoing as needed.

Statewide training on the implementation of the revisions to Administrative Rule He-M 426 and IROS has occurred and will be continued via site visits as needed.

Training via teleconferencing and video conferencing for rural areas, and others is provided.

The Foundation Skills Trainings to date have consisted of Stages of Change, Motivational Interviewing, and Cognitive-behavioral counseling. These basic skills trainings will continue, adding a menu of other modules.

Expert training is provided to the PSAs based on their needs. Currently, internationally recognized peer support expert Sherry Mead is conducting training in Intentional Peer Support for staff of all the Peer Support Agencies.

The Office of Consumer Affairs position is coordinating training activities for BBH consumers, and provides training in wellness management for the BBH consumer community statewide.

The New Hampshire-Dartmouth Psychiatric Research Center of Dartmouth Medical School, mental health centers, and consultants provide training to both mental health centers and substance abuse treatment providers. Additionally, the Office of Alcohol and Drug Policy offers a continual series of training on addiction science and treatment, which is well-attended by CMHC staff statewide.

Although not training per se, the articulation and practice of Targeted Case Management is being substantively communicated by the Bureau to all affected providers and for the awareness of other stakeholders. Technical assistance in detail, based directly on advisement and clarifications from the Center of Medicaid and Medicare Services (CMS) is provided frequently and all questions and concerns are responded to in a timely manner. This is a major undertaking and the Bureau is devoting much staff time and effort to assisting the Community Mental Health Centers to assure they are in compliance with the regulations.

New Hampshire

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

Emergency Service Provider Training: Adult System

The BBH Disaster Response Behavioral Health Coordinator is an Advisory Board member of the Disaster Behavioral Health Response Team (DBHRT) and the liaison among BBH, the CMHC Emergency Services Departments, and the Designated Receiving Facilities. The Coordinator assists with and advocates for the mental health training for emergency health services, participates in suicide prevention activities, is the liaison to the Office of the Chief Medical Examiner (investigating and participating in Sentinel Event Reviews involving CMHC consumers and other constituents of DHHS), and provides trainings to Police Departments on Involuntary Emergency Admission laws. The staff member is one of the co-chairs of the Youth Suicide Prevention Assembly (YSPA) and is a member of the state's Suicide Prevention Council.

The importance of DBHRT has been underscored in recent years by its responses to multiple regional disaster-related tragedies, such as flooding events, and local disasters, such as unexpected deaths of students and suicides of individuals known to the mental health system. DBHRT has partnered with NAMI-NH in presenting and implementing the Frameworks program to the New Hampshire National Guard and veteran's groups. This work mirrors the work being done at the national level to address the mental health needs of National Guard soldiers and the high incidence of suicide within this population, and allows the National Guard to receive timely information about the suicide deaths of any National Guard service member so that immediate postvention responses can be offered to survivors. Also See Part C, Section III, Criterion 1, Array of Services for a description of NH's pilot for Joint Family Support for the NH National Guard that goes well beyond the emergency services of DBHRT.

The BBH staff is also a member of the state's committee developing protocols for the establishment of Family Assistance Centers (FAC) following an event in which there are massive numbers of fatalities. Training will be offered to numerous groups throughout the state on how to participate and respond if an FAC is established, including offering this to members of the CMHCs Emergency Services departments and especially DBHRT members. BBH and the CMHCs serve the members of the community at large who are vulnerable to behavioral health crises during times of disaster through the continued implementation of regional Behavioral Health Disaster Response Plans. Northern Human Services (Region I) Regional Plan for FY09 provides one "snapshot" of how the CMHCs and their regional partners are involved in emergency service training. It is noted that disaster response planning is particularly important in rural northern New Hampshire where there is a dearth of Public Health officials. Per the Disaster Response Plan, Northern's State Disaster Recovery Behavioral Health Coordinator, in conjunction with DBHRT, will:

- Maintain relationships with Regional Public Health Network (PHN) areas and sites
- Interface with local hospitals and Red Cross chapters and other Region I stakeholders
- Provide training and support to DBHRT members and facilitate drills and exercises
- throughout the Region
- Prepare a readiness plan for Eastern Equine Encephalitis and the avian flu

All of New Hampshire's CMHCs are involved in regional planning and training in behavioral health emergency/disaster response.

New Hampshire

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Grant Expenditure Manner: Adult System

The MH block grant in NH is still expended primarily on the contracts with the PSAs, although there have been some changes. The grant also funds the operational needs of the State Planning Council and supports the State Planner position assigned to the block grant, which provides staff support to the State Planning Council and coordinates other block grant-related activities, such as the recently implemented State Plan Advisory Project. The budget for the State Planning Council includes, but is not limited to, funds for graphic publications, training, meeting accommodations, consulting fees/honorarium, office supplies, postage and printing, and selected software.

Currently the grant is also supporting the Mental Health and Aging Consumer Advisory Council, which is otherwise unfunded. The grant is providing a modest financial accommodation to offset the cost of travel for attendees who otherwise would be unable to participate. This group has agreed to provide input on mental health and aging for the State Plan Advisory Project for FY09.

Additionally, the grant will allocate $30,000 in FY09, and $15,000 in each of FY10 and FY11 to help seed the establishment of Project RENEW, largely funded by the Endowment for Health. This initiative addresses an unmet need, expanding services for transitional-age youth with SED.

A change in the payment process beginning in FY08 is that the Peer Support payments will no longer rely on deficit spending from the block grant anticipated awards, as in the past. Now the payments will be drawn from the general funds first. Then when the grant is approved and BBH has received the notice of award, the future payments will be made from the block grant. This should enable easier planning of the grant allocations internally, especially regarding the support of the State Planning Council and the State Plan Advisory Project.

The table below itemizes the block grant expenditures planned for FY09, based on the FY08 award of $1,587,666.

Block Grant Expenditures	**FY 09 Block Grant (estimated)**
I Alternative Life Center (PSA)	280,626
II Stepping Stones (PSA)	225,766
III Lakes Reg. C.A.B. (PSA)	226,214
V Granite State Monarchs (PSA)	110,280
VII A Way To Better Living (PSA)	199,726
VIII Seacoast Consumer Alliance (PSA)	132,875
IX Tri City Consumers Action Coop. (PSA)	107,576
X Circle of L.I.F.E. (PSA)	108,861
State Planning (Staff , Project, and Council Support)	165,742
Project RENEW	30,000
TOTAL	1,587,666

Table C. MHBG Funding for Transformation Activities
State: New Hampshire

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☒		
GOAL 2: Mental Health Care is Consumer and Family Driven	☒		
GOAL 3: Disparities in Mental Health Services are Eliminated	☒		
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☐		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☒		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☒		
Total MHBG Funds	N/A	0	0

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

The amount per goal cannot be estimated. The entirety of New Hampshire's FY09 block grant award, including the administrative portion, is expended in support of: (1) the contracted services of the Peer Support Agencies located statewide; (2) the position of the State Planner, which oversees the block grant, reviews Regional Plans and assists in the maintenance of the State Planning Council; (3) Project RENEW for transitional-age youth; (4) operational needs of the State Planning Council and the MH and Aging Consumer Advisory Council; (5) State performance measures involving the Peer Support Agencies and the State Planning Council, and; the State Plan Advisory Project. All of the activities associated with the expenditure of the block grant are tied to the New Freedom Commission Goals 1,2, 3, and 5.

New Hampshire

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State''s transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Table C-Description of Transformation Activities. This section is limited to those activities supported by the Block Grant funds, at 100% of the NH award, excepting Goal # 4.

NFC Goal 1: Americans Understand that Mental Health is Essential to Overall Health

- The State Planning Council activities deliver this core message across the age span
- Peer Support Agencies promote this message through their programs and relationships with their communities.

NFC Goal 2: Mental Health Care is Consumer and Family Driven

- Peer Support Agencies are developing and conducting a State Performance Measure
- Fiscal and operational support of the State Mental Health Planning and Advisory Council
- Staff support for the State Mental Health Planning and Advisory Council
- State Planning Council involved in developing the State transformation measures for the adult and children's systems, addressing transition issues of youth and young adults
- The PSAs are supported by BBH in implementing the Intentional Peer Support model and IPS Certification process; financial support will be increased for this initiative
- A member of the Mental Health and Aging Council participates in the implementation planning phase of the Mental Health Commission's work, and the council is participating in a State Plan Advisory Project

NFC Goal 3: Disparities in Mental Health Services are Eliminated

- The State Planner and other BBH staff provide extensive technical assistance to the State Planning Council and the Peer Support Agencies, in support of addressing this issue
- Technical assistance is provided to the PSAs for budgeting, financial management, and programming, including access to expert consultation.
- Transition planning and practices provided for youth age 14-17 and young adults age 18-24 in the mental health system are being reviewed by the State Planning Council
- Project RENEW, a national model for services to transitional aged youth is being partially funded by the block grant
-

NFC Goal 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice

None of these activities are funded by the block grant, however CMHC programs conduct assessment and referral, and through contracts, supportive funding and alliances, early screening may occur in programs not directly tied to the SMHA, such as referrals to other resources made by the Infant Mental Health Teams, mental health and substance use screening of older adults through REAP, or services through Special Medical Services for children/youth with special health care needs (supported by Title V), as just a few examples.

NFC Goal 5: Excellent Mental Health Care is Delivered and Research is Accelerated

- The Quality Improvement Team is conducting reviews of all the Peer Support Agencies
- The State Planner is on the QI team, participating in all reviews of Peer Support Agencies
- Peer support services are solicited by issuing RFP's, the proposals are reviewed and scored, and the contracts include performance domains

- Training in the utilization of NH mental health data is provided to the State Planning Council

NFC Goal 6: Technology is Used to Access Mental Health Care and Information

- A new statistical format is being implemented for Peer Support Agency electronic reporting and technical assistance is provided; financial indicators are monitored
- A Web-based survey generator is being purchased to assist the PSAs to obtain feedback from their participants and members, for program development purposes; the Planning Council will also have access to the tool for Council purposes
- The State Planning and Advisory Council continues to explore the feasibility of utilizing teleconferencing and/or videoconferencing to expand input from distant areas of the state and individuals with mobility issues.
- The SMHA is seeking to develop a web-based presence for the State Planning Council.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	8,718	8,801	8,889	8,978	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:	Ensure that adults with SMI are accessing services through the public mental health system
Target:	Expand access to services to the estimated number of adults with SMI by a minimum of 1% over the previous year's actual count
Population:	State-eligible adults with SMI
Criterion:	2:Mental Health System Data Epidemiology 3:Children"s Services
Indicator:	The number of State-eligible adults with SMI served in the public system
Measure:	Actual count of State-eligible adults with SMI in the public system
Sources of Information:	URS Table 14A
Special Issues:	NH eligibility criteria definitions are used to estimate the number of adults with SMI who receive services; NH definitions are more restrictive than federal definitions
Significance:	NOM #1 Increased Access to Services - New Hampshire adults with SMI who are eligible for State services shall be served in the public mental health system
Action Plan:	Monitor service utilization, and analyze trends at each CMHC and statewide; work with CMHCs on an individual basis to support appropriate service access

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	17.68	16.47	15.50	14.50	N/A	N/A
Numerator	278	273	--	--	--	--
Denominator	1,572	1,658	--	--	--	--

Table Descriptors:

Goal: Assure appropriate supports for adults being discharged from New Hampshire Hospital (continuity of care)

Target: Reduce the number of non-forensic readmissions to NHH within 30 days of discharge by a minimum of 1% each year

Population: Adults admitted to New Hampshire Hospital

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of (non-forensic) readmissions to NHH within 30 days of discharge

Measure: Numerator-the number of adults who are readmitted to NHH within 30 days
Denominator-the number of adults discharged from NHH during the past year

Sources of Information: URS Table 20A

Special Issues: The need for inpatient psychiatric beds, especially in the communities, is growing while the number of available beds is decreasing. In addition to the 10 inpatient psychiatric beds in the North Country eliminated due to the DRF hospital closing, a plan to contract for beds in central NH fell through without resolution to the shortage; recently two other hospitals closed their psychiatric inpatient units; housing post-discharge and community supports are limited.

Significance: NOM #2 Reduced Utilization of Psychiatric Inpatient Beds - 30 days; adults shall have sufficient discharge planning, aftercare, and community supports to prevent or reduce their readmission to the State psychiatric hospital within 30 days of discharge

Action Plan: Identify and contract for new crisis beds in other hospitals; pilot ACT team in high-utilization area; provide technical assistance for Person-Centered Treatment to CMHCs; continue to assess barriers and gaps in community supports

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	29.58	29.01	28.50	N/A	N/A	N/A
Numerator	465	481	--	--	--	--
Denominator	1,572	1,658	--	--	--	--

Table Descriptors:

Goal: Prevent adults from being re-hospitalized within 6 months of a discharge

Target: Reduce the number of adult non-forensic readmissions to NHH within 180 days of discharge by a minimum of .5% each year

Population: Adults admitted to New Hampshire Hospital

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of adult non-forensic readmissions to NHH (State hospital) within 6 months of discharge

Measure: Numerator-the number of adults who are readmitted to NHH within 6 months of discharge
Denominator-the number of adults discharged from NHH during the past year

Sources of Information: URS Table 20A

Special Issues: The need for inpatient psychiatric beds, especially in the communities, is growing while the number of available beds is decreasing. In addition to the 10 inpatient psychiatric beds in the North Country eliminated due to the DRF hospital closing, a plan to contract for beds in central NH fell through without resolution to the shortage; recently two other hospitals closed their psychiatric inpatient units; housing post discharge and community supports are limited.

Significance: NOM #2 Reduced Utilization of Psychiatric Inpatient Beds - 180 days; adults shall have sufficient discharge planning, aftercare, and community supports to prevent or reduce their readmission to the State psychiatric hospital within 180 days of a discharge

Action Plan: Identify and contract for new crisis beds in other hospitals; pilot ACT team in high-utilization area; provide technical assistance for Person-Centered Treatment to CMHCs; continue to assess barriers and gaps in community supports

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: NH does not conduct this EBP at this time

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	5.62	7.92	8.90	9.90	N/A	N/A
Numerator	563	697	--	--	--	--
Denominator	10,023	8,801	--	--	--	--

Table Descriptors:

Goal: Support and increase the access to, and maintenance of, the competitive employment of adults with SMI in their communities

Target: The number of adults receiving Supported Employment (SE) will increase by a minimum of 1% of the denominator each year

Population: State-eligible adults with SMI in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Number of adults receiving Supported Employment (penetration rate)

Measure: Numerator-the number of adults with SMI receiving Supported Employment services
Denominator-the number of adults with SMI in the public system

Sources of Information: BBH information system

Special Issues: SE is not reported under a separate billing code; SE is not reported in URS Table 16 NH; eligibility criteria definitions are used to estimate the number of adults with SMI who receive services; NH definitions are more restrictive than federal definitions. Data for 2006 may be unrepresentative due to system start-up issues.

Significance: NOM #3 Evidence Based - Number of Persons Receiving SE; reducing barriers such as the eligibility restrictions of many employment-related programs should assist adults with SMI to attain and maintain competitive employment; SE, with high fidelity, is proven to be an effective service for individuals with SMI seeking competitive employment, and helps to reduce disparities by enhancing supports for those persons

Action Plan: Continue all work-related supports and programs; monitor performance of MOU with Vocational Rehabilitation to accelerate Supported Employment activities within CMHCs; provide training and technical assistance to all CMHCs; monitor fidelity and penetration

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Support adults with SMI to maintain their housing, employment and other aspects of daily living in their communities and prevent/reduce their incidence of rehospitalizations

Target: Establish and maintain an ACT team in 2008 in one region in an urban area of the state

Population: State-eligible Adults with SMI in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The number of adults receiving services from the ACT program

Measure: Numerator-the number of adults who are enrolled in ACT
Denominator-the number of adults with SMI receiving services

Sources of Information: BBH information system

Special Issues: Must establish a baseline in FY09 to determine the desired rate of increase annually in the number served; fidelity will not be measured; there is no billing code for ACT; ACT is not reported in URS Table 16; NH eligibility criteria definitions are used to estimate the number of adults with SMI who receive services; NH definitions are more restrictive than federal definitions

Significance: NOM #3 Evidence Based - Number of Persons Receiving Assertive Community Treatment; programs utilizing ACT teams are proven to be an effective approach for maximizing supports in the natural environment for individuals identified as likely to benefit from ACT, and helps to reduce disparities by enhancing supports for those persons

Action Plan: Establish the ACT pilot in the city of Nashua; evaluate pilot and determine whether ACT will be implemented in one or more additional CMHCs.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: NH does not conduct this EBP at this time

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: NH does not conduct this EBP at this time

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	2.48	5.84	6.80	7.80	N/A	N/A
Numerator	249	514	--	--	--	--
Denominator	10,023	8,801	--	--	--	--

Table Descriptors:

Goal: Support and increase resiliency/recovery-oriented self-care and the optimal wellness of adults with SMI in their communities

Target: The number of adults receiving Illness Management and Recovery will increase by a minimum of 1%

Population: State-eligible adults with SMI in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children''s Services

Indicator: Percent of adults receiving Illness Management and Recovery

Measure: Numerator-the number of adults with SMI receiving IMR
Denominator-the number of adults with SMI in the public system

Sources of Information: URS Table 17

Special Issues: NH eligibility criteria definitions are used to estimate the number of adults with SMI who receive services; NH definitions are more restrictive than federal definitions. Data for 2006 may be unrepresentative due to system start-up issues.

Significance: NOM #3 Evidence Based - Number of Persons Receiving Illness Self-Management; persons with SMI are likely to benefit from supports that assist them in enhancing self-care and that focus on health and well-being rather than the negative aspects of living with the impairment; the IMR model, with high fidelity, is proven to be an effective support for individuals engaged in IMR services

Action Plan: Provide training and technical assistance to all CMHCs; monitor fidelity and penetration

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: NH does not conduct this EBP at this time

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	52.51	N/A	54.51	55.51	N/A	N/A
Numerator	356	0	--	--	--	--
Denominator	678	N/A	--	--	--	--

Table Descriptors:

Goal: Consumers will be satisfied with the services they receive and their treatment outcomes

Target: The percent of adults with SMI reporting positively on treatment outcomes will increase by a minimum of 1% each year

Population: Adults with SMI in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percent of adults with SMI reporting positively on access to services

Measure: Nominator-the number of positive responses
Denominator-the total number of responses

Sources of Information: URS Table 11; Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys

Special Issues: BBH has created a new contract to improve quality of data; the former survey process was not conducted as usual in late FY07 due to the plan to conduct the new survey in early FY08; this survey process is expected to be more useful for state and regional planning purposes

Significance: NOM #4 Client Perception of Care - how participants in the services feel about, and perceive, their own satisfaction with the results provides useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system and reflects the valuing of a consumer-driven system of care

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	42.49	39.16	40.16	41.16	N/A	N/A
Numerator	4,942	5,368	--	--	--	--
Denominator	11,631	13,708	--	--	--	--

Table Descriptors:

Goal: The public mental health system will support adults in attaining and maintaining competitive employment in the community

Target: The percent of adults employed shall increase by a minimum of 1% each year

Population: Adults in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percent of adults reporting employment at the time of inquiry

Measure: Numerator-the number of adults who are competitively employed full or part time (includes Supported Employment)
Denominator-the number of adults who are receiving services; excludes data reported as "not available"

Sources of Information: URS Table 4

Special Issues:

Significance: NOM #5 Adult - Increase/Retained Employment; viable employment at a living-wage is generally valued, desired, and necessary for individuals with SMI who wish to, and are able to, work at a paid job

Action Plan: Continued provision of all work-related supports and programs; monitor performance of MOU with Vocational Rehabilitation to accelerate Supported Employment activities within the CMHCs

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	56.82	76.19	77	78	N/A	N/A
Numerator	25	16	--	--	--	--
Denominator	44	21	--	--	--	--

Table Descriptors:

Goal: To support adults with SMI in preventing and reducing their involvement with the criminal justice system, and, while in services, address the criminalization of SMI-related behaviors and associated stigma

Target: The percent of adults with SMI who report not being rearrested during the most recent 12 month period, when they had been arrested during the prior 12 month period, will increase by a minimum of 1% each year

Population: Adults with SMI in the public system who have been arrested

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children''s Services

Indicator: MHSIP survey responses will indicate a decrease in the repeat arrest rate of adults with SMI

Measure: Nominator-the number of people arrested in year one (T1) who were not rearrested in year two (T2), new and continuing clients combined
Denominator-the number of people arrested in year one (T1), new and continuing clients combined

Sources of Information: URS Table 19A; Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys

Special Issues: BBH has created a new contract to improve quality of data; therefore the former survey process was not conducted as usual in late FY07 due to the plan to conduct the new survey in early FY08; this survey process is expected to be more useful for state and regional planning purposes

Significance: NOM #6 Adult - Decreased Criminal Justice Involvement; reducing or eliminating involvement of persons with SMI with the police/courts/jails/prisons is generally deemed desirable by the individuals, their families, and their communities; stigma associated with SMI is often heightened by the involvement with criminal activity; persons with SMI often do not receive adequate and appropriate mental health care while in the correctional system, and coordinated discharge planning and follow-up by MH providers is often lacking

Action Plan: Conduct the surveys, share and analyze the data with the Community Mental Health Centers; continue to provide technical assistance to existing and planned mental health courts; provision of technical assistance for Person-Centered Treatment to CMHCs

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1.65	1.60	1.10	.60	N/A	N/A
Numerator	155	151	--	--	--	--
Denominator	9,372	9,421	--	--	--	--

Table Descriptors:

Goal: To assist adults who homeless, including being in shelters, engage in CMHC mental health services that support the attainment of a safe, stable, affordable, and adequate living situation

Target: The percent of adults reporting being homeless or in shelters shall be decreased by .5% from the prior year's actual count

Population: Adults in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percent of adults reporting being homeless, including being in shelters

Measure: Numerator- the number of adults reporting their living situation as homeless/shelter
Denominator-the number of adults; excluding data reported as "other" and "not available"

Sources of Information: URS Table 15

Special Issues: Reporting categories "other" and "N/A" are excluded from the counts; together they constitute 56% of the adult responses; as such, the usefulness of this data is significantly limited.;t he data reporting problems are associated with the start-up of the new reporting system;

Significance: NOM #7 Adult - Increased Stability in Housing; lack of adequate, safe, stable, and affordable housing is likely to be detrimental to supporting resiliency and recovery for individuals with SMI; homelessness is a condition that significantly increases disparities in health care, including lack of access to services and barriers to service utilization

Action Plan: Continued provision of full service array appropriate to individual's needs; provide technical assistance for Person-Centered Treatment to CMHCs; provide technical assistance to the CMHCs, with the possibility of an incentive award for improved data collection and reporting on this element

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	57.50	58.50	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Adults with SMI will have social supports that enhance their social connectedness

Target: The percent of adults with SMI reporting positively about social supports and social connectedness will increase by a minimum of 1% each year.

Population: Adults with SMI in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: MHSIP survey responses will yield a percent that is increasing each year.

Measure: Nominator-the number of positive responses
Denominator-the total number of responses

Sources of Information: URS Table 9: Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys

Special Issues: This measure was not in place "as is" in FY07 due to an incorrect understanding of the measure. The notice of modification was sent to CMHS in March 2008, to address the pending contract to have the MHSIP survey professionally conducted in FY08.

Significance: NOM #8 Adult - Increased Social Supports/Social Connectedness; persons with SMI are known to generally benefit, as are most human beings, from a healthy, interactive, social environment, and by having an array of social supports to draw upon for enhancing self-care; survey results provide useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system and reflects the valuing of a consumer-driven system of care

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders; establish a baseline from the FY08 final statistical reporting form.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	0	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Adults with SMI will experience improved levels of functioning over time

Target: The percent of adults with SMI reporting positively about their level of functioning will increase by a minimum of 1% each year

Population: Adults with SMI in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: MHSIP survey responses will yield a percent that is increasing each year

Measure: Nominator-the number of positive responses
Denominator-the total number of responses

Sources of Information: URS Table 9: Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys

Special Issues: This measure was not in place "as is" in FY07 due to an incorrect understanding of the measure. The notice of modification was sent to CMHS in March 2008, to address the pending contract to have the MHSIP survey professionally conducted in FY08.

Significance: NOM #9 Adult - Improved Level of Functioning; self-report of functioning/improved functioning by a person with SMI is valuable to the person regarding his/her own resiliency, recovery, and self-care, and provides useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system, and reflects the valuing of a consumer-driven system of care

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders; establish a baseline from the final FY08 statistical reporting form.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Increased Private Residence Status

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	87.50	88.49	89.49	90.49	N/A	N/A
Numerator	8,190	8,336	--	--	--	--
Denominator	9,359	9,420	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE PERFORMANCE MEASURE. The goal is to assist adults who are without a stable living situation engage in CMHC mental health services that support the attainment of a safe, adequate, and stable living situation

Target: The percent of adults reporting living in a private residence shall increase by 1% from the prior year's actual count

Population: Adults in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The percent of adults with SMI reporting private residences

Measure: Numerator- the number of adults reporting their current living situation to be a private residence
Denominator-the number of adults for whom we have housing information

Sources of Information: URS Table 15

Special Issues: Reporting categories "other" and "N/A" are excluded from the counts; together they constitute 56% of the adult responses; as such, the usefulness of this data is limited; the data reporting problems are associated with the start-up of the new reporting system; living in a private residence is generally viewed to be more stable than other settings, so NH has elected to use this data...anticipating an improved reporting of this data...for a State performance measure

Significance: NOM # 7 Adult - Increased Stability in Housing; lack of adequate, safe, and affordable housing and/or a stable living situation is counter to supporting resiliency and recovery for individuals with SMI and adds to disparities in health care.

Action Plan: Analyze and share the data with the Community Mental Health Centers; continued provision of full service array appropriate to individual's needs; provide technical assistance for Person-Centered Treatment to CMHCs; provide technical assistance to the CMHCs, with the possibility of an incentive award for improved data collection and reporting on this element

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Mental Health and Aging Advisory Project

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	100	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To receive advisory input from the MH and Aging Consumer Advisory Council relative to the State Plan and the planning process for system transformation involving services to older adults with SMI in the public system

Target: The MH & Aging Consumer Advisory Council will provide a written report for the State Plan Advisory Project that addresses one or more priority issues in NH's public MH system affecting older adults with SMI and their families, including recommendations

Population: Primary: Adults with SMI age 60 and over
Secondary: Families of adults age 50 and over with mental illness or serious mental illness
Tertiary: Adults with SMI age 50-59

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: A completed work product based on 100% completion of the work plan (percent)

Measure: Numerator: the number of work plan elements completed by the Year 1 due date
Denominator: the number of work plan elements for Year 1

Sources of Information: Office of the BBH State Planner

Special Issues: In recent years consumer and family input regarding older adults with SMI receiving services in the public system has been underrepresented in the review of the State Plan and the planning process; participation of this group in the State Plan Advisory Project is designed to increase such representation in the planning process

Significance: NOM #1: Increased Access to Services-Adult; NFC Goal #2: Mental Health Care is Consumer and Family Driven; service planning for specific populations benefits from including the perspectives and recommendations of the specific population

Action Plan: A priority for the State Plan Advisory Project will be identified by the MH & Aging Council by September 2008; a work plan for Year 1 of the project will be completed by October 2008; the work plan, as mutually approved by the State Planner and the council, will be operational no later than January 2009; the Planner and representatives of the MH & Aging Council will confer regularly to determine the status of the work plan; a report of the project including recommendations will be completed and provided to the Bureau no later than June 30, 2009.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: PATH Homeless Outreach

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	81.91	91.18	N/A	N/A	N/A	N/A
Numerator	1,168	1,106	--	--	--	--
Denominator	1,426	1,213	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE PERFORMANCE MEASURE-the goal is to maintain the service level established by the FY06 data for the number of adults served by PATH funds. These funds have not increased in over five years, at approximately $300,000 per year of award.

Target: The percent of adults enrolled as PATH clients will remain at or above 85% of the total number of people served by the PATH outreach workers.

Population: Homeless adults with serious mental illness (SMI)

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: The percent of adults enrolled as PATH clients.

Measure: Numerator-the number of PATH clients enrolled
Denominator-the number of adults served by PATH outreach workers

Sources of Information: The Bureau of Homeless and Housing information system (PATH database)

Special Issues: The SFY reports lag behind a year due to the time of release. Fluctuations in census may be expected as a result of many factors regarding contracts, staffing, program development, flat funding and so forth.

Significance: NOM # 7 Adult - Increased Stability in Housing; lack of adequate, safe, and affordable housing is counter to supporting resiliency and recovery for individuals with SMI and adds to disparities in health care for homeless persons.

Action Plan: Monitor the service level of the PATH outreach workers.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Peer Support Agencies Utilization

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE PERFORMANCE MEASURE- the goal is to determine unduplicated counts of members in Peer Support Agencies (PSAs) partially funded by the MH block grant

Target: The State-supported PSAs will record and report unduplicated counts of annual membership

Population: Adults with mental illness (self-report) utilizing peer support in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of individuals reported to be members of the PSAs will increase by 1% annually from the baseline determined in FY10

Measure: Numerator: the number of members reported as active during the reporting period
Denominator: the number of members reported as a baseline in FY10

Sources of Information: BBH Information System

Special Issues: This is a new reporting process and a new statistical reporting form; collection and reporting issues will be addressed during the first year of implementation; the first year of reporting is expected to render an overcount until the statewide training and systemadjustments are completed; it is expected that a viable baseline will be able to be identified with confidence no later than FY10, which will be the second year of reporting

Significance: NOM #1: Increased Access to Service-Adult; NOM #8: Increased Social Support/Social Connectedness-Adult; NFC Goal # 2: Mental Health Care is Consumer and Family Driven; an accurate knowledge of PSA utililzation is necessary for program planning and system transformation planning

Action Plan: Implement the reporting instrument and address emergent issues with the provision of technical assistance

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Peer Support Agency Member Survey

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	100	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE PERFORMANCE MEASURE - the goal is to receive input from members of Peer Support Agencies (PSAs) that will contribute to State mental health planning and system transformation; this is a State Plan Advisory Project

Target: Ten PSAs will offer the "What Do You Think?" survey to all of their members and results will be shared with the SMHA

Population: Adults with mental illness (self-report) who are members of a Peer Support center

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Surveys completed (percent)

Measure: Numerator-the number of completed surveys
Denominator-the unduplicated count of PSA members

Sources of Information: PSA required reporting; completed surveys

Special Issues: This is a non-scientific sample of people who engage as members in Peer Support Agencies; PSA input has been underrepresented in the State Plan due to the lack of any associated performance measures; the PSAs participation in the State Plan Advisory Project increases the representation of this population in the block grant application itself

Significance: NOM #8 - Increased Social Supports/Social Connectedness; NFC Goal #2: Mental Health Care is Consumer/Family Driven; service planning for specific populations benefits from including the perspectives and recommendations of the specific population; consumer input from members of PSAs is important for shaping the SMHA's planning process for State-funded peer support and Intentional Peer Support certifications in New Hampshire

Action Plan: State Planner and PSA Executive Directors of PSAs will confer regularly regarding all key aspects of survey development, conducting of the survey, and survey results; FY09 results will establish a baseline for a response rate for future similar survey-based projects related to consumer input

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Peer Support Agency Participant Survey

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	100	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE PERFORMANCE MEASURE - the goal is to receive input from participants (non-members) of Peer Support Agencies (PSAs) that will contribute to State mental health planning and system transformation; this is a State Plan Advisory Project

Target: Ten PSAs will offer the "What Do You Think?" survey to all of their participants and share the results with the SMHA

Population: Adults with mental illness (self-report) who are particpants at a Peer Support center

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Surveys completed (percent)

Measure: Numerator-the number of completed surveys
Denominator-the unduplicated count of PSA participants

Sources of Information: PSA required reporting; completed surveys

Special Issues: This is a non-scientific sample of people who engage as participatns at Peer Support Agencies; PSA input has been underrepresented in the State Plan due to the lack of associated performance measures; the PSAs participation in the State Plan Advisory Project increases the representation of this population in the block grant application itself

Significance: NOM #8 - Increased Social Supports/Social Connectedness; NFC Goal #2: Mental Health Care is Consumer/Family Driven; service planning for specific populations benefits from including the perspectives and recommendations of the specific population; consumer input from particpants at PSAs is important for shaping the SMHA's planning process for State-funded peer support and Intentional Peer Support certifications in New Hampshire

Action Plan: State Planner and PSA Executive Directors of PSAs will confer regularly regarding all key aspects of survey development, conducting of the survey, and survey results. FY09 results will establish a baseline for a response rate for future similar survey-based projects related to consumer input

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Transition Practices for Adolescents and Young Adults

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	100	100	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE TRANSFORMATION MEASURE-the goal is to improve the delivery of transition services to meet the needs of adolescents and young adults

Target: The work plan will be 100% completed, for the development of a proposed plan for improving mental health services and supports to transition aged adolescents and young adults, with implementation of a pilot within two years.

Population: Young adults age 18-24 in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The percentage extent of the completion of the work plan

Measure: Completion of all elements of the work plan for each year of the performance period

Sources of Information: Office of the BBH State Planner; NH State Mental Health Planning and Advisory Council

Special Issues: This is a new State transformation measure for young adults age 18-24, matched by an identical new State transformation in the Children's Plan (for adolescents age 14-17); this is the first cross-system performance measure targeting NH's transition practices for youth/young adults

Significance: NOM #1, Increased Access to Services and all New Freedom Commission Goals, #1 through 6. New Hampshire is taking the innovative approach of crossing two age groups and their respective service systems, children and adult, with one measure. It is also an innovative approach in that the Planning Council and the Bureau are active partners in the development of this measure; transition-specific activities for the identified age group are known to be a service gap in the NH public mental health system

Action Plan: Analysis of the current needs and supports; an initial report on the present system with recommendations, due by June 30, 2008; the FY09 action step is to be developed subsequent to the report by the State MH Planning Council in collaboration with BBH, and will include the formation of an interagency work group to draft a recommended statewide protocol for addressing the transition issues of this population

New Hampshire

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

Establishment of System of Care

This is a joint response. Please see the narrative for the Adult Plan.

Relative to Children's Services, RSA 135 states: that "eligibility for services in the mental health system for persons under 21 years of age shall be determined after consideration of the services provided under RSA 186-C, RSA 169-B, RSA 169-C, RSA 169-D, or any other law." RSA 135-C:14, titled Optional Services, states that "the department may provide services to persons in need of mental health treatment who are not severely mentally disabled and may provide prevention, emergency, information and referral, consultation, education and other services to individuals and organizations without regard to eligibility and *shall give special emphasis to children and elderly* who need mental health intervention." The laws quoted above refer to child protection, juvenile justice (RSA 169) and special education (RSA 186). See Criterion 3 Children's Plan for a discussion of the children's system integrated services.

New Hampshire

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Available Services

This is a joint response. Please see the Adult Plan for the complete service array.

Included in the service array listed in the Adult Plan, the following should be especially noted.

Specialized services to children and adolescents who are eligible for services pursuant to Administrative Rule He-M 401:

♦ Services provided to eligible children shall be community-based and provided in natural settings.

♦ Services provided to children shall include the following:

Family support and education, including designation of a family liaison;
Psychiatric diagnostic and medication services;
Case management, including appropriate interagency involvement;
Individual, family, and group therapy;
Intake and assessment;
Crisis intervention;
Outreach support to children and their families, both in their homes and in community settings;
Respite care;
Sexual offender assessments and treatment, and;
Treatment of attachment disorder.

♦ Intake, emergency, case management, and other services when performed by children's services staff, are allocated to the children's program.

See Criterion 3, Children's Plan, this Section, for a further discussion of specific services.

New Hampshire

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

Estimate of Prevalence: Children's System

These are 2007 statistics, from the New Hampshire URS tables, the Bristol Observatory (NH data sets), and the US Census for NH. The Bristol data was analyzed using the Probabilistic Population Estimation statistical procedure of Steven Banks and John Pandiani, for NH's new Population Overlap Estimation project. The POE data corrects the overlap in the current URS table data, due to NH not having an unduplicated counting system. The POE unduplicated count, measured over several years, indicates a 5.2% rate of duplication.

Consumers of all ages receiving publicly funded mental health services in community mental health settings numbered 46,906 (FY07-URS duplicated count).Approximately 3.5% of the NH adult population is served in the public mental health system, per the URS data. This is over 35,000 adults served. Mental illness prevalence for the state is estimated by SAMHSA to be approximately 5.4% of the adult population. This is about 54,500 people. Important note: The federal definitions for serious mental illness are less restrictive than the State definitions for State-eligible SMI, and therefore the State definitions are applicable to a smaller segment of the population served.

State Population	**1,309,940**
Number of adults living in state (US Census)	1,009,036
Number of adults with serious mental illness living in state (federal est.)	54,487
Number of State-eligible adults with serious mental illness served (URS)	8,801
State prevalence for adult serious mental illness (federal est.)	5.4%
Percent of adults with SMI served in public mental health system (state def.)	16%
Percent of adults with SMI served in private system or not served (fed. def.)	84%
Number of adult recipients of community mental health services (URS)	35,174
Percent of adult population served in the public MH system	3.5%
Percent of State-eligible adults of all adults served in the CMHC system URS)	25%

The State-eligible population is the priority population to be served with BBH funding to the Community Mental Health Centers, and BBH conducts annual eligibility audits at each of the CMHCs to confirm that the eligible population is receiving the required services. Per URS Table 2a, 2007, the CMHCs served 26,373 adults who were not State-eligible adults with SMI, or 75% of the 10 CMHCs adult service enrollment per the URS data.

It is of note that as the data reporting, collection, and analysis improves we are beginning to identify a growing population of individuals who do not meet the criteria for State-eligible services, may not have private insurance or Medicaid, and have low incomes. The community mental health system is the resource most utilized by this segment of the population, and it is being stretched to the limits, financially.

New Hampshire

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Quantitative Targets: Children's System

This is a joint response. Please see the Adult Plan.

New Hampshire

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

System of Integrated Services: Children's System

By statute, responsibility for children's mental health services involves five public entities:

- Bureau of Behavioral Health: RSA 135C
- Division for Juvenile Justice Services (DJJS): RSA 169-B and RSA 169-D
- Division for Children, Youth and Families (DCYF): RSA 169-C
- Special Medical Services (SMS): Children with Special Health Care Needs: RSA 132-13
- Special Education through local School Administrative Units (SAU): RSA 186-C

These five entities with families and youth are required partners in conducting ongoing planning for regional children's mental health programs. Regional planning supports the development of the State Plan, progress reporting, the transformation of the children's mental health service system, and statewide initiatives to create integrated children's services.

The Children's Regional Plans submitted annually by the ten CHMCs describe well over a hundred regional and local resources. The quantity and types of resources vary statewide, but most regions have a strong complement of resources for families of children with SED supporting service integration. The local CMHC participates as the lead agency in the planning process. The Children's Director and a team of representatives of DJJS, DCYF, local providers of children's health care, local Special Education, and families, conduct the planning, and support implementation of the approved Plan. The process should include substance abuse treatment/prevention providers, public/private child serving agencies, and stakeholders reflecting local culture and community.

One FY09 Children's Regional Plan was selected to provide a sampling of the resources characteristically available in support of increasing the integration of children's services. Seacoast Mental Health Center (SMHC) Child, Adolescent and Family Services, Portsmouth, NH, Region VIII was picked in a blind draw. The use of excerpts from the SMHC Children's Regional Plan does not carry any judgment regarding this center among all the centers.

Participants in the Seacoast planning meetings included representatives from the key state agencies, plus Families First, Head Start, NAMI, Portsmouth Police Department, Allies in Substance Abuse Prevention, the Raymond Coalition for Youth, the Child Advocacy Center, and family members, among others. The May meeting was used "...to identify new goals to collectively work towards... (and to note the) positive changes in cross-agency communication, collaboration, and partnering (in)...shared goals. (The)...result has been improved access to care."

Raymond is a community of approximately 10,000 in southeastern NH, and is just one of the twenty-four cities in the Seacoast service area. The Raymond Coalition for Youth has been successful in recruiting parents and youth into the group and includes representatives from Big Brothers Big Sisters, the UNH Cooperative Extension, educators, and law enforcement. The coalition did a community risk and protective factor survey to identify areas to focus on. Of note, the Coalition "...successfully implemented the Frameworks Youth Suicide Prevention Project after a full year of development and training...This gateway model shows promise in identifying children at risk and getting services in place rapidly." Additionally, UNH is analyzing data

collected from the project, which indicates "...that gatekeepers are referring more youth for mental health and emergency services."

Resources in the region contribute to an SMHC fund called Helping Hands. Business organizations, churches, the Rotary, and the local hospital have contributed to provide camp experiences, recreational pursuits, school supplies, and enrichment activities for children with SED. The agency utilizes other resources to meet the needs of children/youth with SED and hearing impairments, HIV/AIDS, and autistic spectrum disorders, for example.

BBH contracts for family mutual support services that include family-to-family education and support, youth leadership development and other family education, including wraparound training with families and providers. NAMI NH has been awarded the current contract to provide family mutual support, education, an anti stigma campaign, and public education across the life span and that includes families of children. Under a separate grant, NAMI NH is also providing education and support to families of adolescents with mental illness and their families. See Part C Section II, Recent Significant Achievements: Adult System.

The Bureau has a longstanding commitment to work with families and family agencies. Family agencies participated in the redesign of regional planning for the children's programs, and are participants in the Integrated Children's Services Teams, the Children's IROS/EBP Steering Committee, Infant Mental Health, the Mental Health and Schools Together-NH (MAST-NH) grant initiative, and participate in the quarterly BBH meetings with the CMHC children's directors, among other activities.

DCYF and BBH collaborate to ensure that all children entering foster care in the state are screened for mental health issues through all ten local CMHCs. The centers receive funding from DCYF to provide co-located consultation to DCYF staff at the local DHHS district office.

DJJS and the Office of Drug and Alcohol Policy participate with BBH and family agency representatives in a state-level Juvenile Justice/Mental Health/Substance Abuse work group to improve access to mental health and substance abuse services for youth involved in the juvenile justice system, including how to inform and educate the public on the CHINS process (Children in Need of Supervision) and identifying the substance use treatment programs that are available and how to inform agency staff of these resources.

BBH utilizes the New Hampshire Hospital (NHH) Admission and Discharge Protocols that were developed collaboratively to guide access to, planning with, and discharge from NHH. The protocols are for DCYF, DJJS, Schools, families and CMHCs. Supervisory staff are trained on the protocols in both agencies as are children's directors at CMHCs. They have been an effective tool to support continuity of care to help maintain a focus on collaborative discharge planning.

BBH requires through contract that all CMHCs provide a substance abuse screening for youth at intake. Many CMHCs have licensed alcohol and drug abuse counselors (LADCS) on staff.

Relative to education services, NH schools participate in the Medicaid to Schools program administrated by the DHHS Division for Developmental Services. This program allows for some

mental health services to be used for those youth having individual education plans (IEPS). Billing is through local school districts and services are part of the NH Medicaid State Plan.

Other activities involving education services include a project with the Department of Education contractors for PBIS development and through the Safe and Drug Free Schools Initiative called Mental Health and Schools Together (MAST NH). BBH provided leadership in the planning and implementation of the MAST-NH grant initiative, which was sponsored by the U.S. Department of Education Office of Drug-Free Schools. Through infrastructure development and staff training, MAST-NH resulted in increased access to mental health services for students with intensive-level needs. MAST-NH also produced a training session, the "Mental Health and Schools Primer", which has already been presented to 1,068 school staff members. Integrated with PBIS, twenty-five schools also have a documented process for referring identified at-risk students to school-based teams. Additional training was provided to school staff in identifying at-risk students and in de-escalating student behavior in a school setting.

One goal is to improve linkages in five regions in schools with PBIS to mental health and other community providers. Six community mental health centers partnered with twenty-five schools and have developed School-Mental Health Referral Protocols. The protocols detail a process through which families are supported in accessing mental health services for their children. Another goal of MAST NH is to increase the capacity of wraparound facilitators and more importantly to improve fidelity to the practices. Seventy-two new wraparound facilitators were trained under MAST-NH. A total of eighteen experienced wraparound trainers have formed a network of peer support and mentoring and the use of fidelity instruments. Using another small grant from the IDEA Partnership, BBH and the DOE are describing current and past practices as a baseline for improvement activities. Most CMHCs provide some form of in-school mental health services. Also planned is cross training for school and CMHC staff in Functional Behavioral Analysis. A survey of children's program directors was conducted to gain input

Communication and involvement of CMHC staff with MAST-NH schools is being supported by children's program directors who, in the survey, indicated an interest in staff training opportunities that will support both mental health treatment plans and school behavior support plans. Increasing school staff capacity to partner with families and mental health providers is addressed through the Mental Health and Schools Primer training. MAST-NH efforts will be sustained through an Interagency Agreement among CMHCs, School Districts and DJJS and through continued activities of the MAST-NH Statewide Leadership Team, which has committed to continuing their work beyond the grant funding period. The MAST-NH Statewide Leadership Team will be reaching out to all ten CHMCs as they continue their work.

Within DHHS and across departments with the DOE, collaboration is occurring to improve services in the areas of infant mental health and services to youth transitioning to adulthood. Fourteen regional infant mental health planning teams are funded through a braided funding contract managed by DCYF, with funding participation from BBH, Special Medical Services, Maternal and Child Health, Head Start Collaborative, DCYF Child Development Bureau (Child Care), Early Supports and Services, and Preschool Special Education (IDEA parts B&C). These regional teams are over eight years old and produce annual action plans for improving service access for the children's population of ages 0-6, and their families. A current focus for the

network and some local teams is improved linkages with local pediatricians and primary care, as well as more recent focus on improving access to substance use services.

Though NH does not have any employment services specifically for youth we have fully implemented the evidenced based practice of Supported Employment, which is inclusive of youth under age 18. Each CMHC determines the specific age range eligible for the service. Supported Employment is in part linked with the Bureau of Vocational Rehabilitation via an interagency agreement.

BBH, along with NAMI NH, the Federation of Families for Children's Mental Health, the NH Parent Information Center and stakeholders from many roles including Education, Vocational Rehabilitation, Developmental Disabilities, Special Medical Services, colleges and universities, local school districts, youth advocates and businesses has been a partner in the development and implementation of the NH Transition Community of Practice which works to improve post high-school outcomes for students. The four priority areas of work are: High School Reform and Dropout Prevention, School-Business Partnerships, Youth Engagement and Leadership Development and Professional Development and Training for All Stakeholders. Partners work in areas of interest to advance work under these priorities. NH is a partnership state of the IDEA Partnership National Community of Practice on Transition, and the IDEA Partnership National Community of Practice on Collaborative School Behavioral Health, sponsored by the US Department of Education, Office of Special Education Programs.

Through New Hampshire's HRSA Strategic Partner Review, Title V and other HRSA grantees have dedicated action steps for addressing mental health integration into primary care. Continuing this partnership, Title V in NH (for children with special health care needs) is exploring new funding opportunities for integrating care.

BBH has chosen a transformation goal for transition services, incorporated in two State performance measures. The measures are applicable to young adults ages 18 through 24 and adolescents ages 14 through 17. They are worded identically in order to conduct the activities for a transition age population of 14-24 year-olds, which cross both the children's and adult's age groups in the NH service system and per the block grant age categories for adults and children. The measures address NOM #1, Increased Access to Services, and all six of the President's New Freedom Commission Goals. The State Planning Council has completed a background paper with recommendations for year two of this measure.

Activities supporting the comprehensive, integrated children's services system, which are transformation activities spanning all six of the New Freedom goals, include:

- Fourteen Infant Mental Health Teams (IMHT) are working on improving services to children birth to age 6, and their families, through education and advocacy.
- Family Mutual Support: NAMI NH provides across the life span, education, support, leadership development, anti stigma campaign and public education.
- Transition Planning: NAMI NH in partnership with the Parent Information Center is providing training and technical assistance through establishing a Transition Mentor to work with those who are/have been at New Hampshire Hospital, a one day conference "Life Under Construction"

, and "Life After High School", an educational series for youth, their families, school staff and agency personnel.

- Integrating Children's Services Initiative: 2 pilot projects in 2 regions to return children with serious SED from out of state or out of community placement
- State Level JJ/MH/SA Strategic Planning Team: promotes improvements in access to mental health and substance services for youth in the juvenile justice system
- Foster Care Mental Health Assessment Project: BBH collaboration with the Division for Children, Youth and Family (DCYF) to have local CMHCs assess the mental health of children entering the foster care program
- The EBP effort for children's services has begun with Partners for Adolescent Trauma Treatment: SAMHSA-funded trauma-focused cognitive behavioral therapy (TFCBT) initiative through the National Child Traumatic Stress Network; this practice is being disseminated to all CMHCs using a teleconferencing infrastructure and the introduction of Disruptive Behaviors.
- An RFP for a Child Assertive Community Treatment (ACT) program has been issued

The current focus in NH for Integrated Children's Services (ICS) includes a plan to use an Administrative Services Organization (ASO) strategy to braid financing and develop care management processes for youth with intensive service needs and their families. This is central to our application for a policy academy to assist in operationalizing an ASO that will focus on transitional aged youth.

The ASO model seeks to braid service dollars from the Division for Children Youth and Families, Division for Juvenile Justice Services, Division for Community Based Care Services (includes Mental Health and Developmental Services), Office of Medicaid Business and Policy, and the Dept. of Education. Pilot projects in two regions have been initiated to return youth placed out-of state back to New Hampshire to reside in less restrictive home and community settings.

TANF programs are administered by DHHS through the 12 District Offices statewide, which also house child protection (DCYF) and juvenile justice (DJJS) field programs. In addition to supporting the integration of children's services through regional planning processes. Through administrative rule BBH requires that CMHC's children's programs prioritize service access to DCYF and DJJS-involved youth.

New Hampshire

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Geographic Area Distribution: Children's System

See Section 1 of the Adult Plan for a map showing the ten mental health regions. The local CMHCs are responsible for insuring coordination of care plans and maintaining relationships with key agencies and providers in their regions.

New Hampshire

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

Outreach to Homeless: Children's System

CMHC's have individual relationships with local homeless shelters. They receive referrals from shelters for clients needing mental health services. For homeless youth receiving services from CMHC programs, care coordination and outreach services, when needed, are provided through case management.

NH is currently utilizing a State performance measure to determine the number (percent) of children with SED who are without a stable living situation, by using the number of children not living in a private residence as a proxy for potential homelessness. The data at the CMHC level supports the centers' efforts to assure that children in out-of-home placements, in addition to those meeting the HUD definition for homeless, are in safe, adequate, and stable-or relatively stable-living situations.

BBH and children's program directors will continue an annual point-in-time survey process to determine how many youth being served by the CMHC's are homeless. The State Planning Council representative from the Bureau of Homeless and Housing Services also contributes to the interagency dialogue on this subject.

House Bill 537, recently enacted, establishes a twelve-member task force on homeless teenagers. The task force includes the Commissioner of the Department of Health and Human Services or designee. The task force that shall:

(1) Investigate the number of homeless youth in the state and the extent of any current or prior relationship to the division of children, youth and families or the division for juvenile justice services;
(2) investigate the needs of homeless youth for employment, education, transportation, housing, nutrition, mental health services, medical and dental care, legal services, and other support services from adults, including the current availability and accessibility of such services;
(3) study the transitional services available to young people who are moving from foster care or other service systems to adult care systems;
(4) review the youth development center master plan and identify any resources or services of the youth services center appropriate for homeless teenagers; and
(5) solicit information and testimony from youth and young adults who are or have been homeless and from agencies and organizations that provide services to homeless youth and young adults, including school assistance and other educational programs, runaway and homeless youth programs, mental health and substance abuse prevention and treatment programs, and New Hampshire Legal Assistance.

New Hampshire

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

Rural Area Services: Children's System

The Bureau contracts with community mental health centers in all areas of our state, which includes the provision of services via satellite sites to reach the most rural parts of the state. All services available at the community mental health centers are available across the age span. Much of New Hampshire would be considered rural and all home and community based services are available to the eligible population. BBH is also utilizing telemedicine for child psychiatry in the northern most part of the state where psychiatric services are at the minimum. Additionally, the Children's Interagency Team regularly addresses such issues.

New Hampshire

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

Resources for Providers: Children's System

This is a joint response. Please see the Adult Plan in addition to the information below.

The retirement of the coordinator for Children's and Adolescent Mental Health Services has posed a severe staffing challenge due to the length of time involved in attaining approval for the Bureau to fill and recruit for the position. Approval for an internal posting was received but subsequently frozen. A waiver to fill on an expedited basis has neither been denied nor released. In the interim, the new administrator for the Community Mental Health Services Program Unit will provide essential coverage and facilitates the ongoing coordination and collaborations with other children's service agencies.

When a new coordinator is hired, he or she will be working with the CMHCs Children's Directors and the array of statewide child/youth/family serving groups and agencies, with a special focus on the integration of children's services. He or she will also work with the State Planner to assure that current and accurate information is provided for the Child Plan, and that the content is fully responsive to the required elements.

BBH is using training and education to impact workforce development issues. In addition to the series of basic skills training (Foundation Skills Training) that is being provided to the general CMHC workforce, the children's system has developed a plan to introduce evidence-based practices (EBPs) to the workforce.

The Dartmouth Trauma Research Center, in partnership with West Central Services and the DHHS Bureau of Behavioral Health was awarded a three-year grant funded through the National Child Traumatic Stress Network (NCTSN). The project is called Partners for Adolescent Trauma Treatment (PATT). The PATT project has introduced Trauma-Focused Cognitive Behavioral Therapy (TFCBT) to all ten CMHC children's programs.

Utilizing a planning grant from the NH Endowment for Health, other foundation and CMHC funds, a statewide videoconferencing infrastructure has been developed that includes the Dartmouth Trauma Research Center and the ten CMHC children's programs. This structure is being used for training, supervision and ongoing mentoring for the implementation of TFCBT.

Proposed plans to introduce up to three new EBPs over the next three years have recently been funded by the NH Endowment for Health for $150,000 for each of three years. EBPS being considered include treatment for Disruptive Behavior Disorders, which is now going forth, Cognitive Behavioral Therapy for anxiety and depression, and trauma treatment for younger children. BBH will be proposing a sustainability plan to support all children's EBPS through a virtual training unit with Dartmouth utilizing the videoconferencing infrastructure.

New Hampshire

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

Emergency Services Provider Training: Children's System

This is a joint response. Please see the Adult Plan.

New Hampshire

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

Grant Expenditure Manner: Children's System

This is a joint response. Please see the Adult Plan.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	8,080	8,028	8,108	8,189	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Ensure that children with SED are accessing services through the public system

Target: Expand access to services to the estimated number of children with SED by a minimum of 1% over the previous year's actual count

Population: State-eligible children with SED in the public system

Criterion: 2:Mental Health System Data Epidemiology
3:Children"s Services

Indicator: The percent of State-eligible children with SED served in the public sys

Measure: Numerator-the number of State-eligible children with SED who received mental health services during the SFY
Denominator-the federally estimated number of children with SED residing in New Hampshire (16,549 at 5.5%)

Sources of Information: URS Table 14A

Special Issues: 1) Child Protection (DCYF) and Juvenile Justice (DJJS), and private providers, serve youth with SED outside of the CMHC system. We do not expect the CMHC treatment levels to approach treated prevalence rate for SED. 2) The number of children served for 2005 is low because of major changes to the data information system.

Significance: NOM #1 - Increased Access to Services; New Hampshire children with SED who are eligible for State services shall be served in the public mental health system

Action Plan: Monitor service utilization, and analyze trends at each CMHC and statewide; work with CMHCs on an individual basis to support appropriate services access

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	10.13	12.08	11	10	N/A	N/A
Numerator	47	54	--	--	--	--
Denominator	464	447	--	--	--	--

Table Descriptors:

Goal: Assure appropriate supports for children and youth being discharged from New Hampshire Hospital (continuity of care)

Target: Reduce the number of non-forensic readmissions to NHH within 30 days of discharge by a minimum of 1% each year

Population: Children with SED in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of readmissions to NHH within 30 days of discharge

Measure: Numerator-the number of children who are readmitted to NHH within 30 days
Denominator-the number of children discharged from NHH during the past year

Sources of Information: URS Table 20A

Special Issues: The position of the coordinator of Children's and Adolescents Community Mental Health Services has been vacant on an extended basis due to a hiring freeze and absence, to date, of a waiver to permit recruitment to fill the position; this position holds primary responsibility for approving admissions of children; the lack of this gatekeeping function may have impacted the readmission rate.

Significance: NOM #2 - Reduced Utilization of Psychiatric Inpatient Beds - 30 days; children with SED shall have sufficient discharge planning, aftercare, and community supports to prevent or reduce their readmission to the State psychiatric hospital within 180 days of a discharge

Action Plan: Maintain or decrease trend of readmissions to NHH and work with individual CMHCs when appropriate; continue to seek the waiver to fill the vacant coordinator's position; pilot child ACT in one region

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	21.34	19.91	18.90	17.90	N/A	N/A
Numerator	99	89	--	--	--	--
Denominator	464	447	--	--	--	--

Table Descriptors:

Goal: Assure appropriate supports for children and youth being discharged from New Hampshire Hospital (continuity of care)

Target: Reduce the number of non-forensic readmissions to NHH within 180 days of discharge by a minimum of 1% each year

Population: Children with SED in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Children with SED in the public system

Measure: Numerator-the number of children who are readmitted to NHH within 180 days
Denominator-the number of children discharged from NHH during the past year

Sources of Information: URS Table 20A

Special Issues: None

Significance: NOM #2 - Reduced Utilization of Psychiatric Inpatient Beds - 180 days-Child; children with SED shall have sufficient discharge planning, aftercare, and community supports to prevent or reduce their readmission to the State psychiatric hospital within 180 days of a discharge

Action Plan: Maintain or decrease trend of readmissions to NHH and work with individual CMHCs when appropriate; pilot child ACT in one region

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: NH does not conduct this EBP at this time

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: NH does not conduct this EBP at this time

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator:

Measure:

Sources of Information:

Special Issues: NH does not conduct this EBP at this time

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	81	68.93	80	81	N/A	N/A
Numerator	226	233	--	--	--	--
Denominator	279	338	--	--	--	--

Table Descriptors:

Goal: Consumers will be satisfied with the services they receive and their access to services

Target: The percent of families of children/youth with SED reporting positively on satifaction with services will increase by a minimum of 1% each year

Population: Children/youth with SED in the public system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: MHSIP survey responses will yield a satisfaction percent that is increasing each year.

Measure: Nominator-the number of positive responses
Denominator-the total number of responses

Sources of Information: URS Table 11: Child and Adolescent Consumer Survey results from the Family Survey

Special Issues: BBH has created a new contract to improve quality of data beginning FY08

Significance: NOM #4 - Client Perception of Care; receiving feedback on consumer satisfaction is useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system and reflects the value of a consumer-driven system of care

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	19.66	20.66	21.66	N/A	N/A
Numerator	N/A	58	--	--	--	--
Denominator	N/A	295	--	--	--	--

Table Descriptors:

Goal: The public mental health system will support children/youth with SED in returning to and/or staying in school by decreasing suspension and expulsion, and increasing school attendance

Target: The percent of families of children/youth with SED reporting positively on increased school attendance will increase by a minimum of 1% each year

Population: Children/youth with SED in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of families of children/youth with SED who reported increased school attendance when compared to total responses of families of children/youth with SED who reported attendance problems

Measure: Numerator-the number of families of children/youth with SED who reported increased school attendance
Denominator-the number of families of children/youth with SED who reported attendance problems

Sources of Information: URS Table 19b- Child and Adolescent Consumer Survey results from the Family Survey

Special Issues: BBH has created a new contract to improve quality of data beginning FY08

Significance: NOM #5 Child - Return to/Stay in School; receiving feedback on consumer satisfaction is useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system and reflects the value of a consumer-driven system of care

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	62.50	61.50	60.50	N/A	N/A
Numerator	N/A	5	--	--	--	--
Denominator	N/A	8	--	--	--	--

Table Descriptors:

Goal: To support children/youth with SED in preventing and reducing crime

Target: The percentage of families of children/youth with SED who report criminal justice involvement will decrease by 1% from the previous year

Population: Children/youth with SED in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of familes of children/youth with SED who reported decreased criminal justice involvement

Measure: Nominator-the number of children/youth reporting an arrest in T1 (year one) who were not arrested in T2 (year two)
Denominator-the total number of children/youth arrested in T1 (year one)

Sources of Information: URS Table 19a -Child and Adolescent Consumer Survey results from the Family Survey

Special Issues: BBH has created a new contract to improve quality of data beginning FY08

Significance: NOM #6 Child - Decreased Criminal Justice Involvement; receiving feedback on consumer satisfaction is useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system and reflects the value of a consumer-driven system of care

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	.63	.10	0	N/A	N/A
Numerator	N/A	23	--	--	--	--
Denominator	N/A	3,659	--	--	--	--

Table Descriptors:

Goal: To assist children/youth who are homeless, including being in shelters, engage in CMHC services that support the attainment of a safe, stable, adequate living situation

Target: The percent of children/youth reporting being homeless, including being in shelters shall be decreased by .5% from the prior year's actual count

Population: Children/youth in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: The percent of children/youth reporting their living situations as homeless/shelter

Measure: Nominator: the number of children reporting their living situation as homeless/shelter
Denomimator: the number of children, excluding data reported as "other" and "not available"

Sources of Information: URS Table 15

Special Issues: Reporting categories "other" and "N/A" are excluded from the counts; together they constitute 67% of the children's responses; as such, the usefulness of this data is significantly limited; the data reporting problems are associated with the start-up of the new reporting system

Significance: NOM #7: Increased Stability in Housing; lack of adequate, safe, affordable, and stable housing is detrimental to supporting resiliency and recovery for children/youth with SED; homelessness is a conditionthat significantly increases disparities inhealth care, including lack of access to services and barriers to service utilization

Action Plan: Continued provision of full service array appropriate to children's needs; provide technical assistance for Person-Centered treatment to CMHCs; provide technical assistance to the CMHCs, with the possibility of an incentive award for improved data collection and reporting on this element

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	61.05	78.99	79.99	80.99	N/A	N/A
Numerator	453	267	--	--	--	--
Denominator	742	338	--	--	--	--

Table Descriptors:

Goal: To support children/youth with SED and families of such children/youth, in increasing their social supports and social connectedness

Target: The percent of families of children/youth with SED reporting positively on social supports/social connectedness will increase by a minimum of 1% each year

Population: Children/youth with SED in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services

Indicator: Percent of positive responses

Measure: Numerator-number of positive responses
Denominator-total number of surveys that had a response to the social support/social connectedness items

Sources of Information: URS Table 9SC: Child/Adolescent Consumer Survey results-Family Survey

Special Issues: BBH has created a new contract to improve quality of data, beginning FY08

Significance: NOM #8 Child - Increased Social Supports/Social Connectedness; children/youth with SED are known to generally benefit, as are most human beings, from a healthy, interactive, social environment, and by having an array of social supports to draw upon for enhancing self-care; survey results provide useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system and reflects the valuing of a consumer-driven system of care

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	61.73	55.92	56.91	57.91	N/A	N/A
Numerator	458	189	--	--	--	--
Denominator	742	338	--	--	--	--

Table Descriptors:

Goal: To support children/youth with SED, and families of such children and youth, in increasing their levels of functioning

Target: The percent of families of children/youth with SED reporting positively on their levels of functioning will increase by a minimum of 1% each year

Population: Children/youth with SED in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children"s Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percent of positive responses

Measure: Numerator- Number of positive responses
Denominator- Total number of responses

Sources of Information: URS Table 9SC: Child/Adolescent Consumer Survey results from the Family Survey: Functioning

Special Issues: BBH has created a new contract to improve quality of data, beginning FY08

Significance: NOM #9 Child - Improved Level of Functioning; survey results provide useful data for service providers, advocates, the State mental health authority, the State Planning Council, legislators, policy makers, and other stakeholders in the public MH system and reflects the valuing of a consumer-driven system of care.

Action Plan: Conduct the surveys, analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Increased Private Residence Status

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	75	93.08	94.08	N/A	N/A	N/A
Numerator	2,930	3,406	--	--	--	--
Denominator	3,085	3,659	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE PERFORMANCE MEASURE-the goal is to assist children/youth with SED who are without a stable living situation engage in CMHC mental health services that support the attainment of a safe, adequate, affordable, and stable living situation

Target: The percent of children/youth reporting living in a private residence shall increase by 1% from the prior year's actual count

Population: Child/youth with SED in the public mental health system

Criterion: 3:Children"s Services

Indicator: The percent of children/youth with SED reporting living in private residences

Measure: Numerator- the number of children/youth with SED reporting their current living situation to be a private residence
Denominator-the number of children/youth with SED for whom we have housing information

Sources of Information: URS Table 15

Special Issues: Reporting categories "other" and "N/A" are excluded from the counts; together they constitute 72.5% of the child responses; as such, the usefulness of this data is limited; the data reporting problems are associated with the start-up of the new reporting system; living in a private residence is generally viewed to be more stable than other settings such as foster care and other out-of-home situations, so NH has elected to use this data for a State performance measure, anticipating improvement in data reporting

Significance: NOM #7 Child - Increased Stability in Housing; lack of adequate, safe, and affordable housing or lack of a stable living situation is likely to be detrimental to supporting resiliency and recovery for children with SED; lack of stable housing is a condition that adds to disparities in health care, including creating barriers to access and utilization of services

Action Plan: Analyze and share the data with the Community MH Centers, the State MH Planning Council, and other stakeholders; provide technical assistance to the CMHCs, with the possibility of an incentive award for improved data collection and reporting on this element

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Transition Practices for Adolescents and Young Adults

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	100	100	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: This is a NH STATE TRANSFORMATION MEASURE-the goal is to improve the delivery of transition services to meet the needs of adolescents and young adults

Target: The work plan will be 100% completed, for the development of a proposed plan for improving mental health services and supports to transition aged adolescents and young adults, with implementation of a pilot within two years.

Population: Adolescents ages 14 through 17

Criterion: 3:Children"s Services

Indicator: The percent of the completion of the work plan (percent)

Measure: Completion of the work plan elements for each year of the performance period

Sources of Information: Office of the BBH State Planner; NH State Mental Health Planning and Advisory Council

Special Issues: This is a State transformation measure for adolescents age 14-17, matched by an identical new State transformation in the Adult Plan for young adults age 18-24; this is the first cross-system performance measure targeting NH's transition practices for youth/young adults

Significance: NOM #1, Increased Access to Services and all New Freedom Commission Goals, #1 through 6. New Hampshire is taking the innovative approach of crossing two age groups and their respective service systems, children and adult, with one measure. It is also an innovative approach in that the Planning Council and the Bureau are active partners in the development of this measure; transition-specific activities for the identified age group are known to be a service gap in the NH public mental health system

Action Plan: Analysis of the current needs and supports; an initial report on the present system with recommendations, due by June 30, 2008; the FY09 action step is to be developed subsequent to the report by the State MH Planning Council in collaboration with BBH, and will include the formation of an interagency work group to draft a recommended statewide protocol for addressing the transition issues of this population

New Hampshire

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

New Hampshire State Mental Health Planning and Advisory Council

c/o NH Bureau of Behavioral Health
105 Pleasant Street, Concord, NH 03301
603-271-5065 1-800-852-3345 Ext. 5065
Fax: 603-271-5040 TDD Access: 1-800-735-2964
Attn: Lee Ustinich, State Planner
603-271-5048 lustinich@dhhs.state.nh.us

Suzanne Harrison, Co-Chair
603-434-5255
sharrison@harrisonconsult.com

Shirley McDougall, Co-Chair
603-536-4074
shirleymcd@gaufo.com

August 27, 2008

Erik G. Riera
Bureau Administrator
105 Pleasant Street
Concord, NH 03301

RE: FY0-9 Block Grant Comment Report

Dear Mr. Riera:

The NH State Mental Health Planning and Advisory Council (NHMHPAC) reviewed the Bureau of Behavioral Health's Community Mental Health Services Block Grant Application for FY09 Plan at its August 12, 2008 meeting. The plan was offered in draft form, via email and by using WebBGas to the members of the NHMHPAC prior to and at the meeting. Comments regarding various aspects of the Block Grant related to structure, statistics and content were requested using feedback forms at meetings, via WebBGas, and via email. Don Hunter, State Plan Workgroup Chair for NHMHPAC, reviewed the Council's performance measure included in the Block Grant. Lee Ustinich, NH State Planner, provided an overview of the changes and new items presented in the FY09 Plan.

As a discussion followed, Lee and Don responded to questions. There were many concerns about the lack of funding included in the state budget; the next steps for the performance measure, the Council's advocacy to support a waiver to allow the Children's Planner position to be reinstated, the success of Project Renew, and the pilot program for best practices for Children with Disruptive Behaviors. The State Planner accepted the comments and made adjustments as necessary. Comments are accepted all year long via email and feedback forms. The State Plan workgroup will also focus on the block grant in more detail throughout the year.

The NH State Mental Health Planning and Advisory Council is still adjusting to the single Council. We have been successful at recruiting a parent of a child with SED, a family member and a representative from Vocational Rehabilitation. The Council will be evaluating the future structure of how the Council is organized and does its work. This

restructuring is a result of NAMHPAC training and the loss of key positions on the Council. Two workgroup chairs resigned due to time restraints, health issues and family issues. A Co-Chair (Children) resigned due to her spouse's job transfer to Maryland. This presents an opportunity for the Council to discover new avenues for success. Council structure and organization is one of the main topics for the September Annual Planning Meeting.

We invited many presenters to help Council members to understand our different agencies and resources. Council members were invited to provide an overview of their Agency. The Council heard presentations from the Dept. of Education, Dept. of Homeless and Housing, Vocational Rehabilitation. Other presenters include John Pandiani from the Bristol Observatory; Charlene Webber, Director of Peer Support Agencies; NAMHPAC; Marty Fuller, Office of Consumer and Family Affairs; and Heidi Johnson, BBH.

Council members participated in the interview process for the Director of Office of Consumer and Family Affairs. The State Plan workgroup held a conference to discuss transition planning. Council members collaborated with the Mental Health Commission to finalize their report and assisted in the planning for the implementation phase. Council members also distributed and supported various trainings and projects such as "Cover the Uninsured".

Council communication with the Bureau of Behavioral Health has improved greatly due to increased availability of conference calling and weekly meetings.

The Council's Monitoring & Evaluation Workgroup successfully advocated for information about how the Bureau develops the State Plan, resulting in a report from the State Planner's office, "How the Bureau Develops the State Plan Required for the Community Mental Health Services Block Grant to the States".

As a Council we are learning to work together with the Bureau of Behavioral Health to accomplish our common Mission. *The Mission of the council is to bring consumers and families representing children and adults of all ages, across the life span, and other stakeholders together as partners and advocates in the creation, expansion, planning, monitoring, and evaluating of the mental health services and systems of care throughout the state.*

Members of the Council participate on other Mental Health committees and groups. These memberships strengthen the Council by providing a more complete view of mental health services and systems throughout the state.

The Council is working through the process of establishing protocols, policies, and systems to insure that everyone's voice is heard and responded to appropriately. We strive to enhance the relationship with the staff support from the Bureau of Behavioral Health and appreciate how difficult their task is especially in these times of budget cuts

and staff reductions. Our volunteer Council is working diligently to support the recovery and sustained independence of all those with mental illness in the state.

Sincerely,

New Hampshire

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

APPENDIX A: New Hampshire FY09 Mental Health Block Grant Application

1. List of Acronyms

2. New Hampshire State Mental Health Planning and Advisory Council: Bylaws

3. New Hampshire State Planning Council Process for Review of the State Plan

4. Transition Issues for Youth: Background Paper for the NH Mental Health Planning and Advisory Council

5. Organizational Charts:
Department of Health and Human Services
Division of Community Based Care Services
Bureau of Behavioral Health

List of Acronyms

AA	Alcoholics Anonymous
ACT	Assertive Community Treatment
APTD	Aid to Permanently and Totally Disabled
APTP	Acute Psychiatric Treatment Program
APRTP	Acute Psychiatric Residential Treatment Program
AUDIT	Alcohol Use Disorders Identification Test
BBH	Bureau of Behavioral Health
BHH	Bureau of Housing and Homeless
CAP	Community Action Program
CCMC	Children's Care Management Collaborative
CRAFFT	Screening test for adolescent alcohol/drug disorders* *The initials represent five elements within the questionnaire (cars, relax, alone, forget, friends, trouble)
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CoP	Community of Practice
DAST	Drug Abuse Screening Test
DBHRT	Disaster Behavioral Health Response Team
DCBCS	Division of Community Based Care Services
DCYF	Division for Children, Youth & Families
DHHS	Department of Health & Human Services
DJJS	Division of Juvenile Justice Services
DOC	Department of Corrections
DOE	Department of Education
DPHS	Division of Public Health Services
DRC	Disabilities Rights Center
DRF	Designated Receiving Facility
EAP	Employee Assistance Program
EBP	Evidence-Based Practices
FSS	Functional Support Services
FY	Fiscal Year
FFY	Federal Fiscal Year
HOIP	Homeless Outreach Intervention and Prevention
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Human Resources Service Administration
HUD	Housing and Urban Development
I-IMR	Integrated-Illness Management and Recovery
IDEA	Individuals with Disabilities Education Act
IEA	Involuntary Emergency Admission
IMR	Illness Management and Recovery
IROS	Individualized Resiliency & Recovery Oriented Services
ISO	Individual Service Options
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JFSAP	Joint Family Support Assistance Program
LADC	Licensed Alcohol and Drug Counselor
MEAD	Medicaid for Employed Adults
MH	Mental Health

MHACC	Mental Health and Aging Consumer Council
MHCC	Mental Health Consumer Council
MHSIP	Mental Health Statistics Improvement Program
MI	Mental Illness
MIMS	Mental Illness Management Services
MI/SA	Mental Illness / Substance Abuse
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MUA/MUP	Medically Underserved Area/Medically Underserved Population (federal)
NAMI-NH	National Association on Mental Illness of New Hampshire
NASMHPD	National Association of State Mental Health Program Directors
NHEP	New Hampshire Employment Program
NHH	New Hampshire Hospital
NHSMHPAC	New Hampshire State Mental Health Planning and Advisory Council
NOM	National Outcome Measure
OCFA	Office of Consumer and Family Affairs
OCME	Office of Chief Medical Examiner
OMBP	Office of Medicaid Business and Policy
OSEP	Office of Special Education Programs
PASARR	Preadmission Screening and Annual Resident Review
PATH	Projects for Assistance in Transition from Homelessness
PATT	Partners in Adolescent Trauma Treatment
PBIS	Positive Behavioral Interventions and Supports
POE	Population Overlap Estimation
PSA	Peer Support Agency
QI	Quality Improvement
REAP	Residential Education, Assistance & Prevention
RFP	Request for Proposals
RSA	Revises Statutes Annotated
SAMHSA	Substance Abuse & Mental Health Services Administration
SAU	School Administration Units
SCHIP	State Children's Health Insurance Program
SE	Supported Employment
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SMI	Serious Mental Illness
SMS	Special Medical Services
SPU	Secure Psychiatric Unit
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TFCBT	Trauma Focused Cognitive behavioral Therapy
THS/MI	Transitional Housing Support/Mentally Ill
URS	Uniform Reporting System
YSPA	Youth Suicide Prevention Assembly

New Hampshire State Mental Health Planning and Advisory Council

Mission Statement

The Mission of the Council is to bring consumers and families representing children and adults, across the life span, and other stakeholders, together as partners and advocates in the creation, expansion, planning, monitoring, and evaluating of the mental health services and systems of care throughout New Hampshire.

BYLAWS

ARTICLE I – NAME

1.1 The name of this unincorporated association shall be the New Hampshire State Mental Health Planning and Advisory Council (the Council).

ARTICLE II – PURPOSE

2.1 The Council is established and maintained by the New Hampshire Bureau of Behavioral Health under the federal block grant for mental health services.
2.2 The Council represents and advocates for adults of all ages with Serious Mental Illness (SMI), and for children and adolescents under age 18 with serious emotional disturbances (SED) in the creation, expansion, planning, and monitoring of a comprehensive, community-based system of mental health care that supports resiliency and recovery for individuals across the lifespan, statewide.

ARTICLE III – DUTIES

3.1 Review the State Mental Health Plans and submit to the State any recommendations for modification.
3.2 Serve as an advocate for adults with serious mental illness, children with severe emotional disturbance, and other individuals with mental illness or emotional problems.
3.3 Monitor, review, and evaluate, not less than once a year, the allocation and adequacy of mental health services within the State.

ARTICLE IV – MEMBERSHIP

4.1 The number of appointed members may be as many as 51.
Consumers, Family Members, and Other
4.2 No less than 51% of the members of the Council shall be: Current or former Consumers with SMI or SED, Family Members of adults with SMI and/or children with SED, and Others.
4.3 The "Others" membership type within the 51% may include interested parties who are not consumers, are not family members, are not State employees, and are not providers. "Others" may be private citizens with an interest in the state mental health system.
4.4 The ratio of parents of children with SED to other consumer/family members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council.
4.5 Adolescents age 14 and over may be appointed to the Council with the same status as adult members.
State Employees and Providers
4.6 Not more than 49% of the Council membership shall be State employees and providers of mental health services.
4.7 State employees will include representatives of these required State agencies:

- Mental Health (BBH)
- Education (DOE)
- Medicaid (OMBP)
- Vocational Rehabilitation (VR)
- Housing (BHH)
- Social Services (DFA)
- Criminal Justice (DOC)
- Juvenile Justice (JJS)

Definitions of providers and mental health services

4.8 Providers of mental health services are any individuals who provide mental health services or staff of agencies or organizations that provide mental health services, including all organizations and individuals that hold contracts with the Bureau of Behavioral Health or other agencies of the State when the contract includes mental health services.

4.8.1 Volunteers and advisory and governing board members shall not be considered providers solely because of such status.

4.9 Mental health services are broadly defined to include, but not be limited to, the mental health services described and regulated under New Hampshire statute RSA 135-C, as well as mental health research and data services, mental health programs, and mental health policy-making.

Appointments and Terms

4.10 Membership to the Council is by appointment of the Administrator of the New Hampshire Bureau of Behavioral Health or designee.

4.10.1 Any individual invited to serve as a member with voting privileges may submit an application for the Bureau's consideration. All appointments are made with primary regard for the needs of the Council.

4.10.2 Removal from an appointment shall be at the discretion of the BBH Administrator or designee.

4.11 Members age 18 and over shall serve for a term of four years.

4.12 Members may seek re-appointment for additional terms. Additional terms are for three years.

4.12.1 Term limits do not apply to youth members under age 18.

4.12.2 Term limits do not apply to the appointees of the required State agencies.

4.13 The members of the Council shall serve without pay, but the Council may recommend that BBH provide for the payment of reasonable and necessary expenses incurred by members in the performance of their duties.

ARTICLE V – MEETINGS

5.1 Members are expected to attend each Council meeting.

5.2 Participation in a Workgroup is a responsibility of all Council members.

5.3 If a Council member is absent from 40% or more of the Council meetings in a 12-month period the Executive Committee may recommend to BBH that the appointment be terminated.

5.4 A member may be considered for a leave of absence from meetings not to exceed six months.

5.5 The Executive Committee shall prepare an annual schedule of regular meetings, in consultation with the Council membership.

5.5.1 The Planning Council shall convene once a year for the purpose of annual planning to identify the primary events for the annual calendar and to review and update the Council's identified priorities.

5.6 Special meetings of the Council may be called by the Chairs, per the Executive Committee, or by a majority vote of the Council.

5.7 The scheduled meetings of the Executive Committee and of Workgroups are considered Council meetings for members who serve on such groups, regarding Council attendance.

5.8 Each group or committee may determine its own schedule of meetings in addition to the meetings on the calendar.

5.9 All regular meetings of the Council shall be open to the public.

5.9.1 An announcement of regular meetings, an agenda, and the minutes of the previous meeting shall be provided to the members at least seven days prior to any meeting.

5.10 For reporting purposes all members are to sign-in at all Council meetings.

5.11 Notes will be taken at each meeting to provide minutes of the meeting.

Quorum

5.12 The Council can take action only when a quorum is present, which shall consist of (1) at least 50% or more of the members, (2) includes at least one elected officer, and (3) 50% or more of those present

must be of the membership category "Consumers, Family Members, and Other".

5.12.1 Once the quorum is attained, it will stand unless a member requests a recount before any given vote.

Alternates

5.13 There shall be no alternates for consumers, family members, or others for Council meetings, regarding attendance and voting.

5.14 Required State agencies, other state employees, and providers are requested to send an alternate to attend meetings in their stead during any absence, but these alternates may not vote.

Rules of Order and Order of Business

5.15 Simple rules of order shall be followed during all Council meetings and Executive Committee meetings.

5.16 In procedural matters during Council meetings not governed by these bylaws or other written protocols, the Chairs will rule, but any ruling of the Chairs may be overturned by a majority vote of members present.

5.17 A standard order of business will be reflected in the agenda format and followed excepting when emergency issues require a change to the order of business, or agenda content.

ARTICLE VI – GOVERNANCE

Powers

6.1 The Council shall have the powers vested in it by these bylaws, along with other reasonable powers as needed to carry out the purposes and duties of the Council.

6.2 The Council may not commit the State of New Hampshire, its employees, providers, or any individual member, concerning any Council matter.

6.3 No member may represent the Council without authorization from the Council.

Executive Committee

6.4 An Executive Committee is to provide governance and oversight of Council activities and operations, and shall have the authority to act for the Council between meetings, other than to change the bylaws.

6.4.1. In guiding the Council the Executive Committee shall derive its direction from the suggestions, requests, and expressions of the full Council membership.

6.5 The Executive Committee shall include:

The two Council Chairs

The two Council Vice-Chairs

The four Chairs of the Workgroups: Advocacy, Membership, Monitoring and Evaluation, and State Plan

The BBH State Planning and Review Specialist

The BBH Children's Services Coordinator

6.6 The Executive Committee is the formal liaison for the Council with the State of New Hampshire.

6.7 The Executive Committee shall report its activities at the next regular meeting of the Council.

6.8 The Executive Committee may designate certain of its meetings to be closed, by majority vote of the Committee.

6.8.1 Meetings of the Executive Committee may be attended by Council members upon advance request, excepting closed meetings.

6.9 The Executive Committee may appoint Chairs of Workgroups, ad hoc committees, and the Chairs of ad hoc committees, by a majority vote at any meeting of the Executive Committee.

6.10 The Executive Committee is responsible for composing the required block grant review letters, based on the comments and recommendations of the Council membership.

6.10.1 The Executive Committee is responsible for composing letters of support and other such Council correspondence.

Procedures and Protocols

6.11 The Executive Committee shall develop procedures and maintain written protocols to conduct the

business of the Council, consistent with the bylaws.

6.11.1 Revision of significant procedures and protocols require the review and approval of the Executive Committee, by majority vote.

Fiscal Year and Calendar Year

6.12 The Council shall use the same fiscal year as the State, which is July 1 of any current calendar year through June 30 of the following calendar year, for required reporting and financial purposes.

6.13 The calendar year shall be used for annual planning purposes and the schedule of meetings.

ARTICLE VII – OFFICERS

7.1 The elected officers of the Council shall be drawn from among consumers and family members age 18 and over.

7.1.1 Members of the membership type "Others" may not be elected to office. State employees and providers may not be elected to office.

7.2 The officers shall be:

One Co-Chair who is an adult consumer or former consumer over age 18 with SMI.

One corresponding Vice-Chair who is a consumer or former consumer of mental health services over age 18.

One Co-Chair who is a parent, guardian, or other primary caretaker of a child under age 18 with SED.

One corresponding Vice-Chair who is a family member of a child under age 18 with SED.

Duties of Council Chairs

7.3 The Council Chairs shall preside over all meetings of the Council.

7.3.1 The Chairs may co-facilitate or may rotate the duty of presiding over meetings.

7.4 The Chairs shall set the agenda for Council meetings in consultation with the Executive Committee.

7.5 The Chairs shall be, by virtue of office, members of all Workgroups and ad hoc committees.

7.6 The Chairs shall perform other duties as the Executive Committee may prescribe.

7.7 The Chairs serve as the official point of contact for the Council.

7.7.1 The Chairs are the signatories for all Council correspondence, excepting that which is signed by a Workgroup Chair for Workgroup purposes.

Duties of Council Vice-Chairs

7.8 A corresponding Vice-Chair shall, in the absence or disability of a Chair, perform the duties of the Chair.

7.9 The Vice-Chairs shall perform other duties as the Executive Committee may prescribe.

7. 10 The Vice-Chairs shall be, by virtue of office, members of all Workgroups and ad hoc committees.

Terms of Officers

7.11 Terms for officers will be two years.

7.12 No officer shall hold more than one elected office at a time or be a Chair of another group or committee while holding office.

Removal, Resignations, and Vacancy of Position

7.13 An officer may be removed by the Executive Committee whenever in its judgment the best interests of the Council would be served by doing so, but such removal shall be without prejudice to the officer's position as a Council member.

7.13.1 Removal may occur only at a closed meeting of the Executive Committee, after at least twenty days notice to the person proposed to be removed.

7.14 Any officer may resign at any time by giving written notice to the Council.

7.15 A vacancy in the office of Council Chair shall be filled by the corresponding Vice-Chair for the remainder of the term.

7.15.1 The Executive Committee shall appoint an eligible and willing Council member as soon as possible to fill a vacancy in the office of Vice-Chair, until the next election.

ARTICLE VIII – VOTING and ELECTIONS

Voting

8.1 All matters requiring action, or approval, by the Council require a vote and a quorum must be present for any voting.

8.2 There shall be two types of voting: (1) written votes, and (2) voice vote (or count of hands).

8.2.1 Written votes: the vote is anonymous and required for certain actions by the Council.

8.2.2 Voice votes or count of hands: the vote is not anonymous and is taken by a verbal vote of yea or nay or a show of hands.

8.2.3 The Executive Committee will determine what actions shall require a formal written vote.

8.3. All members, not on leave, have a vote, excepting the State Planner and the BBH Children's Coordinator.

8.3.1 Guests and visitors may not vote, either by voice vote/hands or by written vote.

8.4 All members of the Executive Committee may vote on Committee matters, excepting BBH staff, who do not vote.

8.5 At least two officers and three Workgroup Chairs must be in attendance in order for the Executive Committee to vote on matters requiring a vote. (As amended 7/08).

Elections

8.6 Elections for officers will be held at the first regular meeting of the calendar year.

8.6.1 Reference the Council Handbook for the protocol for the rotation of the officers.

Nominations

8.7 The process of nominations and elections shall be the responsibility of the Membership Workgroup.

8.7.1 Reference the Council Handbook for the protocol for nominations and elections.

ARTICLE IX – WORKGROUPS AND AD HOC COMMITTEES

9.1 There shall be four Workgroups to support the purpose of the Council:

Advocacy Workgroup: Responsible for serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems in regards to legislation, regulations, services, and other activities deemed relevant by the Council membership.

Membership Workgroup: Responsible for membership recruitment, retention, keeping attendance, marketing, and other aspects contributing to the consumer and family-based growth and development of the Council.

Monitoring and Evaluation Workgroup: Responsible for monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

State Plan Workgroup: Responsible for assisting the Council members with reviewing the State Mental Health Plan, the Implementation Report, and any State submitted modifications. Responsible for coordinating recommendations for State planning emerging from the Workgroups and the membership at large.

9.2 Workgroup Chairs are appointed by the Executive Committee for a term of two years and may be reappointed for up to two additional terms, providing that does not exceed their term of appointment to membership.

9.2.1 The Workgroup members shall submit recommendations for chairmanship to the Executive Committee.

9.3 Chairs of Workgroups and ad hoc committees may be of any membership type.

9.3.1 The Chairs of Workgroups and ad hoc committees must be members of the Council, but the Workgroups and ad hoc committees may have additional participants who are not Council members.

9.4 The Workgroup Chairs and ad hoc committee Chairs represent the will and interests of their groups, in communications with the Executive Committee and Council.

9.4.1 The Workgroup Chairs and ad hoc committee Chairs shall only have the authority to make decisions for the Council and act on those decisions as assigned or approved by the Executive Committee, in consultation with the Council.

Removal, Resignations, and Vacancy of Position

9.5 A Workgroup Chair or ad hoc committee Chair may be removed by the Executive Committee whenever in its judgment the best interests of the Council would be served by doing so, but such removal shall not alter the member's status as a Council member.

9.5.1 Removal may occur only at a closed meeting of the Executive Committee, after at least twenty days notice to the person proposed to be removed.

9.6 Any Workgroup or ad hoc committee Chair may resign at any time by giving written notice to the Council.

9.7 A vacancy in the position of Workgroup Chair or ad hoc committee Chair shall be filled as soon as possible by the Executive Committee. Leave of absence constitutes a vacancy.

9.8 The Workgroups and ad hoc committees shall be responsible for keeping notes of their meetings.

ARTICLE X – RELATIONSHIP WITH THE STATE

10.1 The Bureau of Behavioral Health elects to recognize this body as the single State Mental Health Planning and Advisory Council, as established in January 2007.

10.2 The BBH Administrator is the final authority regarding activities between the Council and BBH.

10.2.1 The Bureau Administrator or designee(s) shall respond in a timely manner to all formal inquiries presented by the Council.

10.2.2 The designee(s) shall keep the Administrator updated on all Council activities.

10.3 To assist the Council in meeting its responsibilities, BBH will provide updated guidance, technical assistance, requests for specific advisories, operational support, staff support and supplies. Support, at a minimum, shall include the active involvement of:

Community Mental Health Services Program Unit Administrator
State Planning and Review Specialist
Children's Services Coordinator
Staff to assist with meeting arrangements and note taking
Other staff with expertise for technical assistance

10.4 The BBH State Planning and Review Specialist assigned to the block grant is responsible for maintaining the Council in accord with the Bureau's guidance.

10.5 Financial support of the Council shall be made available from block grant funds for essential needs in carrying out the Council Purpose, as approved by BBH administration.

10.6 Council work products and records are the property of the State MH authority. BBH will maintain the Council's manual and electronic files, with full Council access.

10.7 There shall be a grievance procedure to resolve issues between the Council and the Bureau, and between the Executive Committee and the members, by written protocol.

ARTICLE XI – ANTI-DISCRIMINATION

11.1 The Council shall not discriminate against any individual or group with regard to any individual or group beliefs, physical or mental characteristics, or any other attributes, actual or perceived.

ARTICLE XII – AMENDEMENT OF BYLAWS

12.1 The Executive Committee may propose amendments to the bylaws. To be enacted, the amendment must be passed by a majority vote of the full Council. A copy of proposed amendments shall be distributed to members at least thirty days prior to the vote.

Adopted by the NH MH PAC January 8, 2008.

New Hampshire State Planning Council Process for Review of the Block Grant State Plan

(Approved by Council on November 13, 2007)

Protocol: The Council will have a structured process for review of the State Mental Health Plan. This process will guide the related activities of the Workgroups and Age Specific Groups.

Process:

1. The Council will identify specific components of the State Mental Health Plan for review.
   - The State Plan Workgroup will make initial recommendations to the Council for consideration and approval. When developing these recommendations, the State Plan Workgroup will give preferential consideration to Council-approved areas of priority.
   - The Council will revise the review process as necessary, in order to maintain the flexibility to develop and adapt approaches that support the Council's goals and responsibilities.

2. The Council will establish an annual schedule for review of the State Mental Health Plan, in coordination with deadlines identified by BBH.
   - The State Plan Workgroup will make initial recommendations to the Council for consideration and approval.
     - The due dates for submission of the Application (September 1), Implementation Report (December 1), and Modifications (due when they occur, if any) for the Block Grant are set by federal Guidance.
   - The review schedule will be set up to ensure there is:
     - Adequate time for a review of the identified goals by the Council and the preparation of Council reports.
     - Adequate time for the State Planner to prepare a draft of any federally required material that requires review and comment by the State Planning Council. BBH will provide the due dates for reviews and Council submissions of materials based on the BBH planning and preparation process.
     - Adequate time to allow for input from the Council on the draft of any federally required material requiring Council review and comment.
     - Adequate time for the Council to review a final draft before submission by BBH. Note that BBH by necessity may make "last minute" pre-submission changes based on internal review and administrative directive.
   - The review schedule will be set up to allow the Workgroups and Council sufficient time to pursue additional business, interests an concerns.

3. Each Workgroup will study the items on the review list from the perspective of their workgroup.
   - Workgroups will be provided a Review Time Schedule.

- Workgroups will provide written reports to the Council membership.
    - These reports should include but not be limited to comments, observations, and recommendations to BBH.
- The review topics will provide general guidance to the Workgroups and Council, allowing them to decide what they want to include in their review. These factors may include, but are not limited to:
    - Appropriate New Freedom Commission goals,
    - State Performance Measures (including some or all of their goals, information sources, and action plans), and
    - Any other relevant materials, whether or not they are part of the State Plan.
- Additional guidelines for the Workgroups include:
    - Examine each goal (including NOMs and SPMs) from their perspective.
    - Ask for any needed technical assistance (TA). Each workgroup is assigned a BBH planner for TA purposes and other resources are available.
    - Review data provided by BBH.
    - Review implementation activities.
    - Ask other questions or express concerns.
    - Undertake activities to advance identified goals.
        - The Workgroups should focus primarily on activities that will result in specific, well-researched recommendations and advisory input to the BBH, consistent with the budget and legislative processes within which the mental health system operates.

4. Age Specific Groups will review the goals in their respective sections of the State Plan not reviewed by the Workgroups.
    - Guidelines for the Age Specific Groups include:
        - Examine each goal from their perspective.
        - Ask for any needed technical assistance.
        - Review data provided by BBH.
        - Review implementation activities.
        - Ask other questions or express concerns.
        - Advise Council on what activities are needed to advance the goals.

5. After consideration and approval by the Council, reports and recommendations prepared by the Workgroups and Age Specific Groups will be compiled and incorporated into Council documents as appropriate.
    - The Council may use these materials in the production of an annual report. This report may also include a listing of Council accomplishments and activities, highlight Council recommendations to BBH, and identify Council goals and priorities for the coming year.

Transition Issues for Youth
Background Paper for the NH Mental Health Planning and Advisory Council

Prepared by the State Plan Workgroup
February 2008

Introduction

This paper represents the next step in Council's first State Plan review. The first step was identifying the Council's priorities. The second step was selecting the topic for the initial focus of the Council's review. The purpose of this paper, the next step, is to provide background and suggest direction for the Council's review activities.

This background paper is offered by the State Plan Workgroup. Much of the wording is summarized from information presented to the Workgroup. The goal of this paper is to:

- Outline the issues related to transitioning youth from the children's mental health services to adult mental health services.
- Provide examples of the transition efforts currently underway in NH.
- Serve as a launching point for the remaining work that the Council and Workgroups need to undertake to complete this review cycle.

After more detailed additional work on this issue, the efforts of the Workgroups and Council should be compiled into a report. This report on transition issues should include an assessment of the State Plan components addressing transition. It should also include data, examples of problems, and recommendations for further actions by the Council, the Bureau of Behavioral Health, and by affected stakeholders in the mental health system, to improve transition processes and services.

Outline of Transition Issues

In general, youth and young adults face a number of risks and challenges as they struggle to become adults. For those also dealing with mental health issues, there are a number of hurdles and opportunities surrounding their transition from the children's system into the adult mental health system.

Transition-age youth in NH have difficulty moving into the adult mental health system. In many instances the level of services and supports received in the adult system are less available and not as extensive as those in the children's system. Their mental health conditions generally continue into adulthood and they are at higher risk for developing new disorders during this period of their lives. When they reach age 18 or 21, they face disruptions in their care due to loss of eligibility for care in the children's system, resulting in a loss of ongoing relationships with caseworkers and service providers. Few of these young people meet the narrower eligibility criteria for accessing services in the adult mental health system. If they are eligible for Medicaid, the eligibility criteria become stricter. Private insurance coverage is also problematic. In addition to losing the continuity of care, they often cannot obtain services that are developmentally appropriate for their age group.

Many in this group also need transition supports and assistance in finding job training and employment, obtaining housing/independent living arrangements, and continuing with their education. Although these issues are major components in the full range of services needed by this group, the Council's focus should remain on the mental health system at this time.

All these problems are compounded for transition-age youth, who have a 40-60% high school dropout rate, high rates of unemployment/underemployment, higher rates of substance abuse than any other age groups with mental illness, and are more likely to be involved in criminal activity than adolescents without mental illness.

Some problems are already recognized, but solutions have not been agreed on and implemented. One example is the lack of a standard system for evaluation or transition from children's to adult's services within the community mental health centers (CMHCs). Each center currently utilizes different definitions and processes. The lack of specialized service providers and appropriate programs is another roadblock, which is compounded by inadequate training opportunities and outreach activities. Another example is that New Hampshire schools are not currently providing sufficient training for transitioning youth to handle real-life, day-to-day activities. Even if such preparation becomes available and is provided successfully, the mental health service system is not currently able to meet the increased demands and expectations. A final example is a restriction imposed by the federal Deficit Reduction Act, which allows each client to have only one case manager, even if they have co-occurring disorders (developmental disabilities and mental health issues). Shortage of funding is a big hurdle to any changes or improvements.

Transition-age youth require assistance in obtaining the preparation, resources and positive development they need to establish connections and become healthy, self-sufficient and successful adults. Too many youth in NH are not receiving the assistance they need and are suffering because of the inadequacies of the mental health system in NH.

Examples of Current Efforts

The following are examples of programs and services that the State Plan Workgroup is aware of. Further information and materials are available regarding all of them.

Young Adult Program

Offered by the Community Council of Nashua, the Young Adult Program (YAP) is designed to assist individuals between the ages of 15 and 20 who are coping with emotional difficulties and transitional living issues. The staff of YAP work with young adults to provide educational and community support, individual and family outreach, coordination of treatment services, and psycho-educational and therapy groups. Staff works closely with other providers to plan needed services. Participants focus on five basic areas of competence while involved in the program: vocational and career planning; daily living skills; recreational and leisure activities; social skills and peer relationships; and symptom management. YAP members learn skills both through groups and by working individually with staff. They are frequently brought into the community to experience hands-on learning.

There are no other YAP programs in NH. Some of the challenges YAP staff raised include: lack of referrals to the program for 18-21 year olds; transportation and logistical problems dealing with multiple schools and towns along with two separate program sites; different attitudes/cultures in children's and adult's systems (including young adults uncomfortable in adult system); the length of time needed to complete transition processes (notify appropriate people and fill out paperwork, then long waits for follow up, lack of availability of staff in adult system to conduct psychological evaluations); big challenges in obtaining benefits when switching from children's to adult's systems; and very limited access to housing (availability and age qualifications).

RENEW (Rehabilitation, Empowerment, Natural supports, Education, and Work)

Project RENEW's mission is to assist youth and young adults to connect with the supports they need in order to overcome barriers to their success. It serves young people between the ages of 15 – 21 and has demonstrated success in using a variety of strategies to help them complete high school, find employment, obtain post-secondary education, and integrate into the community. RENEW is based on the values of self-determination, natural supports, mentoring, and lifelong education.

RENEW now covers the Manchester-Nashua area. Staff are trying to teach the RENEW model to schools in several areas around NH and have also applied for grant funding to provide training to mental health staff. One barrier mentioned was that provisions of the federal No Child Left Behind Act derailed their existing school-to-work efforts.

NAMI NH is involved in several transition efforts, including the following projects.

The Technical Assistance and Training Services for Transition Planning and Youth Leadership Development by the Bureau of Behavioral Health through the Olmstead Act Funds. NAMI NH will partner with The Parent Information Center to provide technical assistance and training to youth/young adults with mental and behavioral challenges, their families, school/agency personnel and community members in working together to improve transitional services for youth.

Youth will be provided with leadership training opportunities to develop an important life skill set. Training and support for youth and young adults with mental and behavioral health challenges is critical if they are to develop self-determination and self-advocacy skills enabling them to be more active in their education, transition and life planning. The following programs and supports will be delivered:

- "Life after High School" is a ten-hour structured training series on transition planning for youth and their teams (families, school/agency personnel, community members who support them.) It will be offered in 4 locations, and have 6-10 youth and members of their teams.
- A Transition Mentor will work with youth at New Hampshire Hospital and their families providing educational and mentoring services for transition planning.
- A Transition Planning Conference will be planned by and for youth and young adults with mental and behavioral health challenges and their families.
- Youth will be recruited and supported to participate in the Adolescents and Young Adult Leadership Program.

New Hampshire is one of ten states (along with federal and local agencies) currently participating in the **National Community of Practice on Transition**. This group promotes collaboration to improve school and post-school outcomes for youth through advancing interagency participation in transition and strengthening the meaningful role of youth in the transition process.

The **Division for Children, Youth and Families** (DCYF) within the Department of Health and Human Services has an Adolescent Program to assist youth who are age 14 and older and in DCYF guardianship, or age 16 and older and in DCYF custody or in an out of home placement through the Division for Juvenile Justice Services (DJJS). This program works to ensure that current and former DCYF and DJJS youth obtain the preparation, resources and positive youth development they need to establish connections with caring adults and become healthy, self sufficient and successful adults. Adolescent Child Protective Service Workers with specialized training lead, educate and collaborate with youth, colleagues and the community to ensure best practices for adolescents. The program offers an adult living preparation process and aftercare services for youth, the NH TRAILS (Teen Responsibility And Independent Living Skills) curriculum for caregivers, has a Youth Advisory Board, and sponsors a Teen Conference.

Barriers to effective transition that DCYF staff raised include lack of housing availability, NH Medicaid insurance coverage for former foster care youth ending at age 19, and youth whose needs can't be met because of lack of adult system service access and availability.

Information on **additional State efforts**, including the **Granite State Employment Project** and ongoing assistance efforts through **Special Medical Services**, was also provided to the Workgroup and is available for review. Certainly the activities of the **Bureau of Behavioral Health**, including the State Plan, need to be thoroughly examined.

Suggested Areas for Further Study

Since this is the Council's first time through the State Plan Review process, the members of the State Plan Workgroup have several general observations. We believe our efforts should focus on the mental health system for now. We need to concentrate on addressing problems and changes in the NH mental health system before we try to reach out to other areas (such as the NH Department of Education). Information and suggestions outside the mental health system can still be compiled, but our primary activities should be directed within the system.

We need to take a good look around us to identify and gather research and information that has already been prepared. This will allow us to make the best use of our time by building on the work of others. A full inventory of resource materials and organizations should be compiled. Part of this effort should include an inventory of activities and programs that are already in place, both within and outside NH, as well as best practices/evidence based practices in this area.

Although our goal is to bring about long-term improvements in the mental health system, there are limits to what we can reasonably expect to accomplish. Since additional funding and staff resources are not practical at this time, we need to identify actions that are relatively "easy" to put into operation. We also need to offer ideas that can be implemented quickly, at the most

effective level, and the closest to our target group of transitioning youth. Strengthened alliances with mental health and youth advocacy groups at the local, state and national levels will leverage the Council's efforts. Longer-term efforts could include changes to NH laws, administrative rules, and budgets, improved cooperation among stakeholders, and increased awareness and advocacy on behalf of transition-age youth.

Further work needs to be done to compare current transition practices at all of the CMHCs. This effort can build on work NAMI has already done. Through their work it is clear that there is no consistency across CMHCs and that none have written transition processes. This comparison could be used to identify, develop and implement a series of NH best practices in a relatively short period of time. These practices could include standard assessment and intake practices, definitions of youth vs. adult, transition eligibility criteria, designation of adolescent specialists, and staff training. Members of the State Plan Workgroup and the group of providers that recently made presentation to the Workgroup have numerous suggestions in this area.

The State Plan Workgroup believes one way to get these changes moving is by recommending that BBH convene a workgroup of transition stakeholders, including child and adult services coordinators, families, and youth. This group would be charged with developing and implementing a range of standard best practices in order to get the transition improvement process moving. The Council could continue to collaborate with this group to work towards longer-term changes.

Next Step for Workgroups/Council

Each workgroup needs to review this background paper and identify areas they can work on. Workgroups may need to take on responsibilities outside their basic charge in order to share the workload and keep this review process moving. The assistance and support of BBH staff will be vital to this process.

We ask each workgroup (and individual Council members) to consider the tasks before us and decide what areas they can help with. These offers should be communicated back to the Council Co-chairs, State Plan Workgroup and the State Planner for coordination.

Comments about this paper, the transition review process, and the future course of action on this project are welcome.

New Hampshire Department of health and Human Services
Organizational Charts

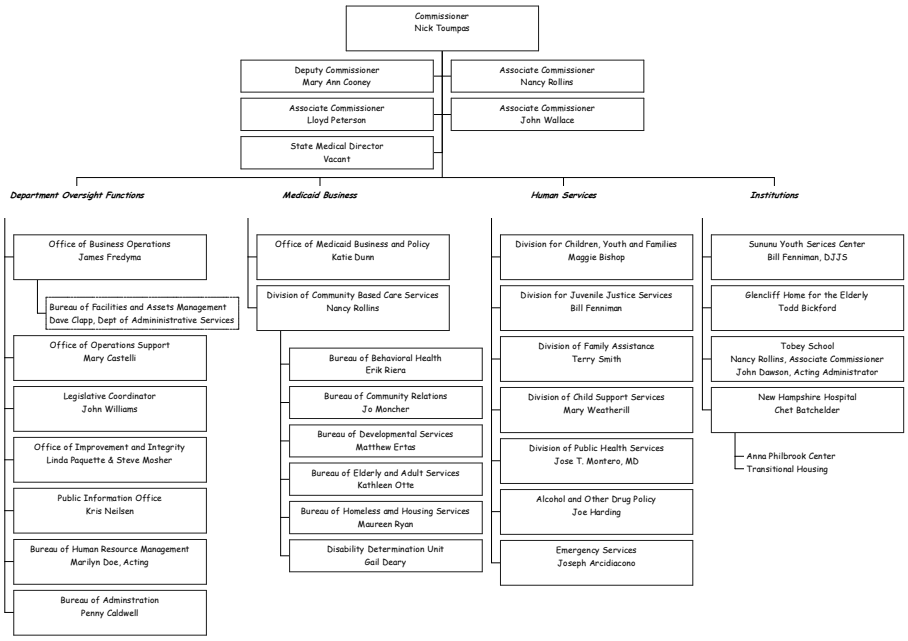
(1) Department of Health and Human Services Functional Chart

(2) Division of Community Based Care Services

(3) Bureau of Behavioral Health

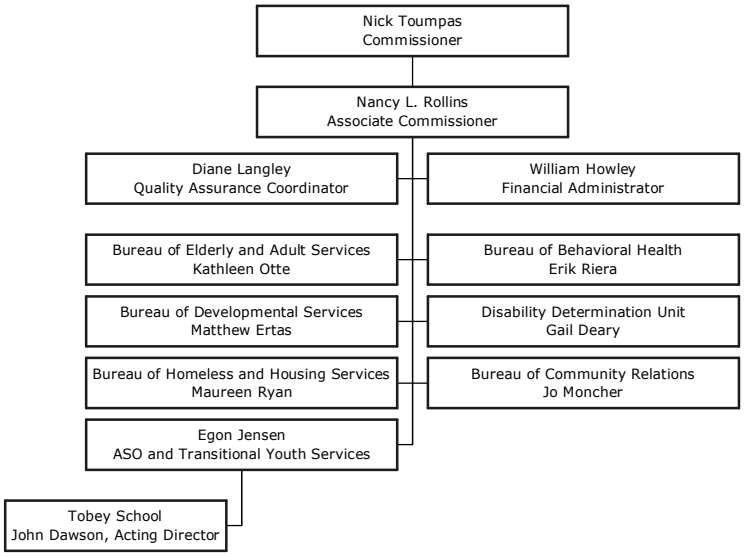
.....Charts are on the following three pages .....

DHHS Functional Organization



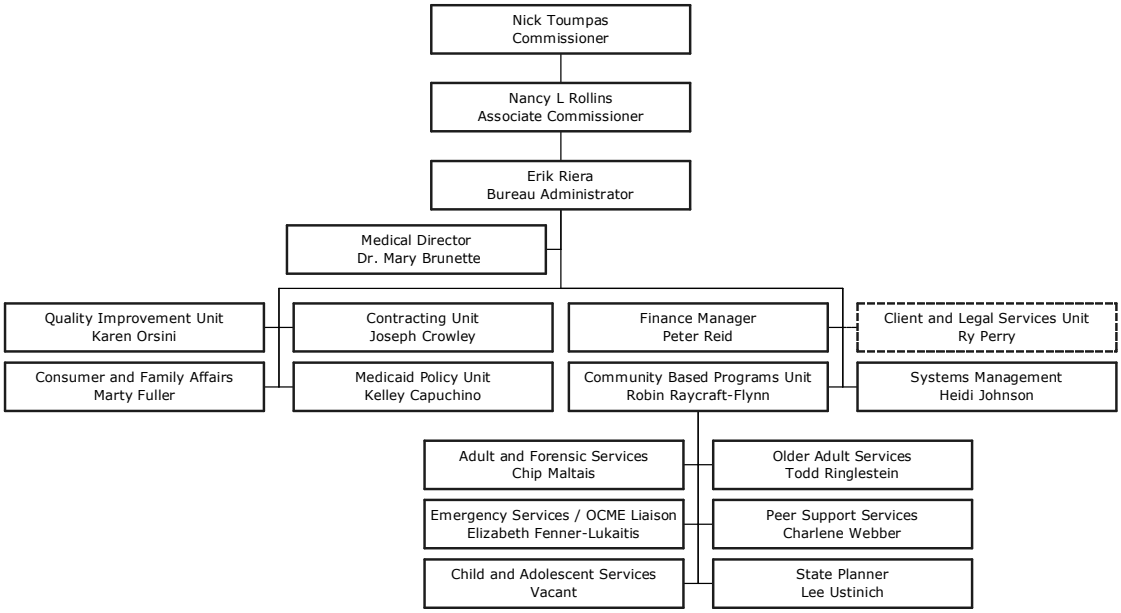
Updated August 2008

Division of Community Based Care Services (DCBCS)



Updated August 2008

Bureau of Behavioral Health (BBH)



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